S. Hrg. 99-670 Pt. 2

BUDGET RECONCILIATION

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

SEPTEMBER 11, 12, AND 13, 1985

PART 2

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
58-304 O WASHINGTON : 1986

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

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CONTENTS

PUBLIC WITNESSES

Page

Castle, Hon. Michael N., Governor of the State of Delaware, and chairman, Human Resources Committee, National Governors' Association 5
Davis, James E., M.D., speaker, American Medical Association House of Delegates 26
Roehrig, Dr. C. Burns, president, American Society of Internal Medicine 52
Censoni, Urbano, chairman, Government Affairs Committee, National Association of State Mental Retardation Program Directors 64
Matula, Barbara D., director, North Carolina Division of Medical Assistance, on behalf of the State Medicaid Directors Association of the American Public Welfare Association 112
Petit, Michael, commissioner, Maine Department of Human Services, on behalf of the National Council of State Human Service Administrators 123
Fulton, Robert, director, Oklahoma Department of Human Services 141
Ruvin, Hon. Harvey, commissioner, National Association of Counties 153
Dempsey, William H., president, Association of American Railroads 180
Kilroy, Richard I., international president, Brotherhood of Railway and Airline Clerks 222
Myers, Robert J., Dr., chairman, Railroad Unemployment Compensation Committee 231
Snyder, James R., chairman, Legislative Committee, Railway Labor Executive Association 242

ADDITIONAL INFORMATION

Committee press release 1
Prepared statement of Senator John Heinz 1
Prepared statement of Senator Max Baucus 2
Prepared statement of Ted Schwinden, Governor, State of Montana 4
Prepared statement of the Honorable Michael N. Castle, Governor of Delaware 8
Prepared statement of the American Medical Association 28
Prepared statement of the American Society of Internal Medicine 54
Prepared statement of Ben Censoni 68
Prepared statement of Barbara D. Matula 114
Prepared statement of Michael R. Petit 125
Prepared statement of Robert Fulton 143
Prepared statement of the Honorable Harvey Ruvin 155
Prepared statement of William H. Dempsey and Charles I. Hopkins, Jr 183
Prepared statement of the labor members of the Railroad Unemployment Compensation Committee 224
Prepared statement of Robert J. Myers 233
Prepared statement of the Railway Labor Executives' Association 244

COMMUNICATIONS

Actuarial Risk Service, Inc 253
Air Carrier Conference of America 262
Aircraft Owners and Pilots Association 276
Air Freight Association 280
American College of Emergency Physicians 287
American College of Surgeons 311
American Foundation for the Blind 316

Page
The American Intra-Ocular Implant Society 325
American Optometric Association 344
Association of American Medical Colleges 352
Chamber of Commerce of the United States of America 367
City of Zeeland, MI 368
Healthcare Financial Management Association 371
International Association of Airport Duty Free Stores 375
KPL Gas Service 377
Board of Supervisors, county of Los Angeles 379
National Air Transportation Association 384
The National Association of Private Psychiatric Hospitals 386
Prospective Payment Assessment Commission 390
National Association of Stevedores 392
The National Coal Association 400
National Council of Health Facilities Finance Authorities 410
The National Education Association 423
Mining and Reclamation Council of America [MARC] 434
The Board of Trustees of the Public School Teachers' Pension and Retirement Fund of Chicago 446
The Railroad Retirement Association 455
School employees retirement system of Ohio 470
State teachers retirement system of Ohio 473
Commonwealth of Kentucky teachers' retirement system 477

BUDGET RECONCILIATION

FRIDAY, SEPTEMBER 13, 1985

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m. in room SD-215, Dirksen Senate Office Building, the Honorable Bob Packwood (chairman) presiding.

Present: Senators Packwood, Chafee, Symms, Grassley, Long, Boren, and Bradley.

[The press release announcing the hearing and the opening statements of Senators Heinz and Baucus and a letter from Gov. Ted Schwinden of Montana follow:]

[Press Release No. 85-067, Friday, Aug. 9, 1985]

SENATE FINANCE COMMITTEE TO BEGIN WORK ON DEFICIT REDUCTION IN EARLY SEPTEMBER

The Senate Finance Committee will hold hearings on deficit reduction on Wednesday, September 11, on Thursday, September 12 and on Friday, September 13, Committee Chairman Bob Packwood (R-Oregon) announced today.

"No problem facing this country is more compelling than our growing Federal budget deficit—action must be taken by Congress now if we are to avert serious economic consequences," Senator Packwood said. "I am convinced that a significant reduction in the deficit will be a boon to the economy, resulting in lower interest rates, more capital available for private business investment and a lower value of the dollar, which will make American products more competitive in the international marketplace."

Pursuant to the Conference Report on S. Con. Res. 32, the first budget resolution adopted by Congress before it adjourned for the August recess, the Finance Committee will consider various ways in which to meet its reconciliation instructions. Under the budget agreement, the Finance Committee is required to reduce spending for programs within its jurisdiction by more than $22 billion over the next three fiscal years (1986-88). In addition, Finance must raise revenues by $8.4 billion over that same period.

In addition to receiving the views of several Administration witnesses, the Committee will receive testimony from public witnesses on various proposed changes to Finance Committee programs.

All of the hearings scheduled by the Committee will begin at 9:30 a.m. in Room SD-215 of the Dirksen Senate Office Building.

STATEMENT OF SENATOR JOHN HEINZ

Mr. Chairman, I would like to thank you for scheduling this hearing on revenue proposals for deficit reduction. We will hear several proposals discussed here today, but I would like to call my colleagues' attention to one in particular.

H.R. 3128, the Deficit Reduction Bill reported by the House Ways and Means Committee on July 31, proposes to make a change in the tax treatment of railroad retirement benefits which I believe would be a mistake. Currently, these benefits have two parts: Tier I—a benefit which very closely resembles social security, and Tier II—a benefit that looks like an industry pension. Tier I is taxed now in the same way as social security—half a person's benefits become taxable roughly when their income exceeds the $25,000/$32,000 cutoff. Tier II is taxed now in the same way as an industry pension—an individual's own contributions are not taxable, but the rest of the benefit becomes fully taxable once the individual's own contributions have been recovered.

Often a Tier I benefit is identical to the benefit that would have been received under the social security system. However, the Tier I benefit may be slightly higher than an equivalent social security benefit. This may happen for several reasons, one of which is that railroad retirement pays unreduced benefits to early retirees or widows. In cases where the Tier I benefit is higher than a social security equivalent, the Ways and Means Committee proposes to tax the portion of the Tier I benefit that is considered excess as a pension and not as a social security benefit.

Thus for many railroad retirees who have not paid a tax on their benefits because their other income was too low, a portion of the Tier I benefit would now be fully taxable. Over 500,000 Tier I beneficiaries would face a tax increase and possible financial hardship. These are the same people who have gone without a cost-of-living adjustment (COLA) and have borne the burden of two tax increases in the past 2 years. Mr. Chairman, I think we would be buying trouble and provoking anger in this group to levy another tax increase on them now.

Not only would this proposal be unfair to railroad retirees but it would also be an administrative nightmare to carry out. It is estimated that 50 percent of the Tier I beneficiaries receive more than would under social security. Consequently, the Railroad Retirement Board would have to recalculate half of all annuity payments, not an administratively easy task and one that requires new information that is not readily accessible.

Ever since 1974, when the Tier I/Tier II scheme was created, congress has sought to extend and clarify the concept that Tier I is equivalent to social security and that Tier II is like an industry pension. In the past 2 years, through the Social Security Amendments of 1983 and the Railroad Retirement Solvency Act of 1983, we have seen that concept be extended to the area of taxation of retirement benefits. In my judgment, this new proposal takes too literal an approach in further defining how these taxes should be calculated. In doing so, it undermines the usefulness of the Tier I/Tier II conceptual framework, would wreak administrative havoc, and unfairly singles out a small group of retirees for a tax increase.

The revenue effect of taxing a portion of Tier I benefits like a private pension is just not worth the headache and anger this will create. The proposal would raise only an estimated $160 million over 3 years. While we all must be committed to reducing the Federal deficit, I seriously question whether the administrative expense involved in implementing this proposal and the financial pressure it brings to bear on up to 500,000 railroad Tier I beneficiaries is really worth the minimal savings incurred. In my judgment, this proposal should be rejected and attention should instead be turned to more feasible and productive means of reducing the deficit.

STATEMENT OF SENATOR MAX BAUCUS

Mr. Chairman, I would like to submit for the record a statement by the Honorable Ted Schwinden, the Governor of Montana, on the proposal to increase the black lung tax on coal. Governor Schwinden opposes this proposal, and I would like to join him in urging that this tax increase not be adopted.

This is the worst possible time to add to the tax burden of American coal producers. Low coal prices and strong competition from foreign producers are putting a great deal of pressure on coal mine operations in Montana, West Virginia, and every other state that produces coal.

Montana's mines are surface coal mines, so our miners don't suffer debilitating diseases like black lung. However, I don't want my opposition to this tax increase to be interpreted as a statement of opposition to the black lung program. I think it is a necessary program and I think it is a good program. I will support any sound proposal to ensure that it is on a secure financial footing. However, the proposal we are considering today is not a sound proposal. As Governor Schwinden has stated, the "problems contributing to the current debt should not be solved merely by increasing the taxes."

I do not think we should blindly double the black lung coal tax with only a limited understanding of the true problems facing the program. I encourage industry and labor to work closely with Congress in examining all of the options available for eliminating the deficit that threatens the solvency of this important program.

Mr. Chairman, I ask that the statement by Governor Schwinden be made a part of the hearing record.

State of Montana
Office of the Governor
Helena 59620

TED SCHWINDEN
GOVERNOR

Statement of
Ted Schwinden, Governor
State of Montana
before the Committee on Finance
United States Senate
September 13, 1985
on H.R. 3128

The State of Montana urges Senators of the Finance Committee not to concur in provisions adopted by the House of Representatives that would increase black lung tax on coal by 50% to service debt accumulated by the black lung disability program.

This tax increase is counterproductive at a time when U.S. coal producers face a stagnant national market and increasing competition from foreign coal. A few cents per ton can make the difference between getting -- or failing to get -- a long term, multi-million ton contract in today's tight markets. Yet the House action would add up to 25 cents per ton, substantially handicapping American coal producers.

Montana does not ask Congress to forego this increased revenue without recognizing that the states should also assist the industry in remaining competitive. Unlike some other states, Montana already provides an exclusion for black lung taxes when computing a producers'state tax liability, thereby reducing our revenue. And, earlier this year, the Montana Legislature enacted my proposal to afford coal producers a one-third credit against our state severance tax on additional coal production.

Since most western coal mines are surface mines, few people in Montana or Wyoming receive the benefits paid out by the black lung program. Nevertheless, we recognize that in our federal system particular regions will pay more into some programs than they receive in benefits, while the reverse will be true for other programs. We do not quarrel with the black lung program as constituted to date.

We do feel, however, that problems contributing to the current debt should not be solved by merely increasing the taxes. Tightened eligibility requirements, reduced cost on inter-fund borrowing, and other approaches available to you should be tried before adopting an action that will add to the problems already facing America's coal industry.

We hope you will reject the tax increase.

The CHAIRMAN. The committee will come to order.

Our first witness this morning is the Honorable Michael Castle, Governor of the State of Delaware. He is appearing here today not only in his capacity as Governor but as chairman of the Human Resources Committee of the National Governors' Association.

I have asked him to testify first. After he is done, we will go to the panel of Dr. Davis and Dr. Roehrig.

Governor, it is good to have you with us.

STATEMENT OF THE HONORABLE MICHAEL N. CASTLE, GOVERNOR OF THE STATE OF DELAWARE, AND CHAIRMAN, HUMAN RESOURCES COMMITTEE, NATIONAL GOVERNORS' ASSOCIATION

Governor CASTLE. Thank you, Senator, and good morning. As chairman of the National Governors' Association's Committee on Human Resources, I want to thank you for providing this opportunity to testify before the Committee on Finance.

Let me say at the outset that the NGA supports and encourages specific Federal deficit reduction actions. We recognize that reducing the deficit will require sacrifices, and the States are willing to see the growth of Federal aid they receive reduced.

In fact, we adopted a bipartisan policy position on the comprehensive Federal budget to that effect in February.

The NGA budget policy, which is discussed in detail in my written testimony, represents an across-the-board approach to Federal spending, one that would require economies from defense, other discretionary programs, and nonmeans tested entitlement, and other mandatory spending programs to reduce the deficit.

But at the same time, we would strongly oppose excessive cuts in programs which help meet the basic needs for the poor, as well as policies which simply shift costs to the States and local governments.

Federal policy which disproportionately shifts costs to the States either reduces real State revenues available for other programs or forces increases in total State expenditures and taxes.

This places an unfair burden upon States which must balance their budgets by State constitutions or State law.

Over the past 6 months, Congress has grappled with this problem, and we believe produced a workable budget package which will reduce the deficit while protecting programs of low-income Americans; for this, we commend the Congress.

We greatly appreciate the efforts of members of the Committee on Finance to achieve a budget resolution that avoids caps or cuts in Federal Medicaid funding or services for the poor.

With respect to the Aid for Families with Dependent Children and Work Incentive Programs, we oppose the budget cutting proposals. Changes in the AFDC Program between 1981 and 1984 already cut benefits and program costs over $2.5 billion net between 1982 and 1985.

We support full funding for these major means-tested entitlement programs administered by States. States and the Federal Government share responsibility for these income security programs, and there is general agreement among the Governors that the Federal role in the partnership is vital and must be maintained, but this partnership is threatened by the system of quality-control error-rate sanctions for the AFDC, Medicaid, and Food Stamp Programs.

Almost every State will be liable for error-rate sanctions for erroneous payments made between 1981 and 1988. The cost is substantial, potentially more than $2 billion.

What is more, depending on the quality-control error-rate sanctions levied against individual States, matching rates for benefits in the AFDC and Medicaid Programs will drop significantly.

The effect is unacceptable. The bulk of the burden for meeting the basic needs of the poor will be shifted to the States, profoundly affecting the States' ability to fund cost-of-living increases and other vital services for low-income people.

Let me emphasize that the Governors support the existence of a quality-control system and believe that fiscal sanctions have a role to play in those systems.

We strongly support congressional action to revise and improve the quality-control systems for the AFDC and Medicaid Programs, but it is ironic that the current quality-control systems mandated by Congress will impose large error-rate sanctions when State error rates are at an all-time low, demonstrating the fundamental success of quality-control as a management system.

For example, in the Aid to Families with Dependent Children Program, official error-rate data shows that errors were reduced to 6.5 percent by September 30, 1983, compared with 16.5 percent in 1973, a reduction of more than 60 percent.

In my own State of Delaware, we have brought our error rate down from 16.1 percent in 1978 to a State-calculated rate of 3.75 percent as of March 1985, a 77-percent decrease.

We have done this by means of a total commitment at all levels to improve the efficiency and accuracy of program administration. Our efforts have included development of a state-of-the-art computerized eligibility system, which has received national recognition, use of a highly structured corrective action process that has been praised by Federal officials, a supervisory review process, and other innovative error-reduction techniques.

Nevertheless, in spite of these efforts, Delaware is liable for sanctions from 1981 onward and will be liable even in 1985 when our error rate is 3.75 percent because the current target is 3 percent.

That is clearly wrong because the ultimate, if unintended, victims of this process are the very people we are trying to help. If the system is not changed, we may find ourselves in the position of reducing vital services for young children because of errors that were made before they were born.

We believe Congress must act to restore the system's usefulness as a management tool, and my written testimony details several steps the NGA believes are necessary to accomplish this.

Senator Daniel Evans has introduced S. 1362, on which he testified yesterday, and which we strongly support. Senator Evans' bill seeks several immediate reforms which are basically consistent with our policy, such as the more reasonable error-rate tolerance of 4 percent, elimination of technical errors, and an official error rate set at the lower bound of the statistical estimate.

For the longer term, Senator Evans' bill would provide for a moratorium on fiscal sanctions until Congress reforms the quality control error-rate tolerances based upon concurrent studies by the Department of Health and Human Services and the National Academy of Sciences.

We offer, Senator, our cooperation and support for the measures that are consistent with our budget policy and will effectively reduce the deficit. I thank you.

The CHAIRMAN. Governor, thank you.

[The prepared written statement of Governor Castle follows:]

National Governors' Association

Lamar Alexander
Governor of Tennessee
Chairman

Raymond C. Scheppach
Executive Director

STATEMENT OF

THE HONORABLE MICHAEL N. CASTLE

GOVERNOR OF DELAWARE

ON BEHALF OF

THE NATIONAL GOVERNORS' ASSOCIATION

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ON

FEDERAL DEFICIT REDUCTION PROPOSALS
AND
THE QUALITY CONTROL SYSTEM
FOR THE
AID TO FAMILIES WITH DEPENDENT CHILDREN PROGRAM

SEPTEMBER 13, 1985

HALL OF THE STATES · 444 North Capitol Street · Washington, D.C. 20001-1572 · (202) 624-5300

GOOD MORNING. AS CHAIRMAN OF THE NATIONAL GOVERNORS' ASSOCIATION'S COMMITTEE ON HUMAN RESOURCES, I WANT TO THANK YOU FOR PROVIDING US AN OPPORTUNITY TO TESTIFY BEFORE THE COMMITTEE. WE SHARE YOUR DESIRE TO MAINTAIN A VITAL GROWING ECONOMY AND BELIEVE THAT SIGNIFICANT REDUCTIONS IN THE FEDERAL DEFICIT ARE NECESSARY TO ACHIEVE THIS GOAL. A GROWING ECONOMY IS ESSENTIAL FOR BALANCING THE FEDERAL BUDGET AND FOR HEALTHY STATE FISCAL CONDITIONS. THEREFORE, WE ARE PLEASED TO SHARE OUR VIEWS ABOUT HOW THE COMMITTEE CAN HELP REDUCE THE LARGE FEDERAL DEFICITS.

LET ME SAY AT THE OUTSET THAT THE NATIONAL GOVERNORS' ASSOCIATION SUPPORTS AND ENCOURAGES SPECIFIC FEDERAL DEFICIT REDUCTION ACTIONS. WE RECOGNIZE THAT REDUCING THE DEFICIT WILL REQUIRE SACRIFICES AND THAT STATES ARE WILLING TO SEE THE GROWTH OF FEDERAL AID THEY RECEIVE REDUCED; WE ADOPTED A BI-PARTISAN POLICY POSITION ON THE COMPREHENSIVE FEDERAL BUDGET TO THAT EFFECT IN FEBRUARY. BUT, AT THE SAME TIME, WE STRONGLY OPPOSE FURTHER CUTS IN PROGRAMS WHICH HELP MEET THE BASIC NEEDS OF THE POOR, AS WELL AS POLICIES WHICH SIMPLY SHIFT COSTS TO STATE AND LOCAL GOVERNMENTS. FEDERAL POLICY WHICH DISPROPORTIONATELY SHIFTS COSTS TO THE STATES EITHER REDUCES REAL STATE REVENUES AVAILABLE FOR OTHER PROGRAMS OR FORCES INCREASES IN TOTAL STATE EXPENDITURES AND TAXES.

THIS PLACES AN UNFAIR BURDEN UPON STATES WHICH MUST BALANCE THEIR BUDGETS BY STATE CONSTITUTIONS OR STATE LAW. MOREOVER -- AND THIS IS VITALLY IMPORTANT -- IT IGNORES THE DRIVING FORCE BEHIND DEFICIT REDUCTION: THE RECOGNITION THAT GOVERNMENT MUST LIVE WITHIN ITS MEANS, THAT IT CANNOT PLACE AN UNFAIR BURDEN ON ITS CITIZENS, EITHER NOW OR IN THE FUTURE. THE PROBLEM THE MEMBERS OF THIS COMMITTEE ARE FACING IS HOW MUCH GOVERNMENT SHOULD SPEND, NOT WHO COLLECTS THE TAXES. SHIFTING THE COST OF PROGRAMS TO THE STATES WILL NOT SOLVE THAT PROBLEM.

THE NGA BUDGET POLICY CALLS FOR DEFICIT REDUCTIONS THAT WOULD BE ACHIEVED BY FREEZING THE 1986 APPROPRIATION AT THE 1985 LEVEL FOR NON-DEFENSE DISCRETIONARY SPENDING. FOR THE 1987-1990 PERIOD THIS COMPONENT WOULD BE INCREASED AT ONE-HALF THE RATE OF INFLATION. NATIONAL DEFENSE APPROPRIATIONS IN 1986 WOULD BE LIMITED TO THE 1985 LEVEL PLUS INFLATION. FOR THE 1986-1990 PERIOD NATIONAL DEFENSE SPENDING WOULD BE ALLOWED TO INCREASE 1-3 PERCENT IN REAL TERMS. THE GROWTH IN OTHER ENTITLEMENT AND MANDATORY SPENDING PROGRAMS WOULD ALSO BE RESTRAINED. PART OF THIS RESTRAINT WOULD BE CAUSED BY A ONE YEAR FREEZE IN ALL COST OF LIVING ADJUSTMENTS INCLUDING SOCIAL SECURITY. FURTHERMORE, THE NGA POLICY URGES THE CONGRESS TO REVIEW THE MEDICARE, FEDERAL PENSIONS, FARM, AND SOCIAL SECURITY PROGRAMS TO DETERMINE WHAT REFORMS CAN BE ENACTED IN THESE NON-MEANS-TESTED ENTITLEMENTS. THE REFORMS WOULD BE

DESIGNED TO INCREASE THE LONG-TERM CONTROLABILITY OF THE FEDERAL BUDGET WHILE FEDERAL SUPPORT FOR NEEDS TESTED PROGRAMS WHICH PROVIDE THE SAFETY NET FOR POOR AMERICANS IS MAINTAINED.

OVER THE PAST SIX MONTHS, CONGRESS GRAPPLED WITH DIFFICULT POLICY OPTIONS AND WE BELIEVE PRODUCED A WORKABLE BUDGET PACKAGE. ACCORDING TO THE CONGRESSIONAL BUDGET OFFICE, THIS BUDGET PACKAGE WILL REDUCE THE FEDERAL DEFICIT AS A PERCENTAGE OF THE GNP FROM 5.5 PERCENT OF GNP FOR FY 1985 TO 2.1 PERCENT FOR FY 1990. WE COMMEND CONGRESS FOR THIS SIGNIFICANT EFFORT.

WE ALSO WISH TO COMMEND CONGRESS FOR PROTECTING PROGRAMS FOR LOW-INCOME AMERICANS. ESPECIALLY RELEVANT TO THIS COMMITTEE, WE WISH TO POINT OUT THAT THE BUDGET RESOLUTION ASSUMES THAT THERE WILL BE NO "MEDICAID CAP", NO BUDGET CUTS IN THE AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) PROGRAM, AND NO ELIMINATION OF THE WORK INCENTIVE (WIN) PROGRAM.

WE GREATLY APPRECIATE THE EFFORTS OF MEMBERS OF THIS COMMITTEE TO ACHIEVE A BUDGET RESOLUTION THAT AVOIDS CAPS OR CUTS IN FEDERAL MEDICAID FUNDING OF SERVICES FOR THE POOR. AS YOU KNOW, NGA STRONGLY OPPOSED THE MEDICAID CAP PROPOSAL BECAUSE IT ALMOST CERTAINLY WOULD HAVE FORCED MANY STATES TO CUT NEEDED SERVICES FOR OUR MOST VULNERABLE CITIZENS. THE PROPOSED CAP WOULD HAVE BEEN INSENSITIVE TO A BROAD RANGE OF ECONOMIC, DEMOGRAPHIC AND HEALTH CARE MARKET FACTORS THAT CAN SIGNIFICANTLY ALTER THE NEED FOR MEDICAID SERVCIES IN A GIVEN STATE.

CUTS IN FEDERAL MEDICAID MATCHING RATES WOULD GREATLY IMPEDE STATE EFFORTS TO MEET THE MEDICAL CARE NEEDS OF OUR POOR ELDERLY, CHILDREN AND MOTHERS. THIS IS PARTICULARLY CRITICAL AT THE PRESENT TIME BECAUSE RECENT COMPETITIVE CHANGES IN THE HEALTH CARE MARKET PLACE ARE MAKING ACCESS TO MEDICAL CARE FAR MORE DIFFICULT FOR INDIGENT PERSONS NOT ELIGIBLE FOR MEDICAID. MEDICAID PRESENTLY COVERS FEWER THAN HALF OF THE NATION'S POOR. AS MEDICARE, MEDICAID AND PRIVATE PAYORS LIMIT THEIR PAYMENTS AND BECOME MORE PRICE-SENSITIVE, HEALTH CARE PROVIDERS ARE LESS ABLE TO CONTINUE FUNDING CHARITY CARE THROUGH PRICE INCREASES TO OTHER PAYORS. STATE EFFORTS TO FINANCE SERVICES FOR POOR PERSONS NOT ELIGIBLE FOR FEDERAL MEDICAID FUNDING WOULD BE SEVERELY HAMPERED BY FEDERAL MEDICAID FUNDING CUTS. WE ARE PLEASED THAT THE COMMITTEE ON FINANCE RECOGNIZES THIS AND INTENDS TO ACHIEVE MEDICAID SAVINGS THROUGH MANAGEMENT IMPROVEMENTS IN THIRD-PARTY RECOVERIES. WE ALSO APPRECIATE THAT THE COMMITTEE'S APPROACH WILL MEASURE STATE PERFORMANCE IN THIS AREA AGAINST A FEDERALLY APPROVED STATE MANAGEMENT IMPROVEMENT PLAN RATHER THAN AGAINST UNSPECIFIED OR ARBITRARY OUTCOME STANDARDS DEVELOPED UNILATERALLY BY FEDERAL AGENCIES.

We also appreciate the Committee's interest in state development of home-and community-based long-term care services under Medicaid, and support any improvements in state latitude you can make in the budget process. As you know, the states have been very frustrated with the regulations and implementation of the waiver authority you enacted in 1981. We look forward to working with you in the future to revise or restructure federal law to facilitate state community care initiatives without increasing federal costs.

The budget resolution also avoids replacing the Work Incentive program with a federally mandated AFDC work program intended to cut federal AFDC benefit costs by $195 million in FY 1986. While the proposed mandate for AFDC work programs would provide for some structural options, such a proposal would be much less flexible than current law. All states either have a WIN or WIN Demonstration program and 37 states are experimenting with job search, community work experience and/or grant diversion/work supplementation programs. These latter program options plus the WIN Demonstration projects are now optional and provide excellent flexibility for states to test what works best. Therefore, we request that the current flexibility be maintained. Furthermore, we support the current funding level for the WIN/WIN Demonstration programs which

WOULD BE REPLACED UNDER THE ADMINISTRATION'S PROPOSAL BY A MUCH SMALLER GRANT TO STATES.

AS I JUST MENTIONED, WE SUPPORT FULL FUNDING FOR THE MAJOR MEANS-TESTED ENTITLEMENT PROGRAMS ADMINISTERED BY STATES. THE STATE AND FEDERAL GOVERNMENTS SHARE RESPONSIBILITY FOR THESE INCOME SECURITY PROGRAMS AND THERE IS GENERAL AGREEMENT AMONG THE GOVERNORS THAT THE FEDERAL ROLE IN THE PARTNERSHIP IS VITAL AND MUST BE MAINTAINED.

BUT THIS PARTNERSHIP IS THREATENED BY THE SYSTEM OF QUALITY CONTROL ERROR RATE SANCTIONS FOR THE AFDC, MEDICAID AND FOOD STAMP PROGRAMS. ALMOST ALL OF THE STATES WILL BE RESTROSPECTIVELY LIABLE FOR ERROR RATE SANCTIONS THAT COULD TOTAL OVER $2 BILLION FOR ERRONEOUS PAYMENTS MADE BETWEEN 1981-1988. IN FACT, 21 STATES FOR 1981, 26 STATES FOR 1982, 36 STATES FOR 1983 AND POSSIBLY 42 STATES FOR 1984 ARE POTENTIALLY LIABLE FOR ERROR RATE SANCTIONS. SANCTIONS OF THIS MAGNITUDE WOULD EFFECTIVELY REDUCE MATCHING FUNDS FOR THESE THREE PROGRAMS. THE FEDERAL GOVERNMENT MATCHES AFDC AND MEDICAID BENEFITS AT RATES BETWEEN 50 AND 78 PERCENT AND MATCHES BASIC ADMINISTRATIVE COSTS AT THE 50 PERCENT RATE. DEPENDING UPON THE QUALITY CONTROL ERROR RATE SANCTIONS LEVIED AGAINST A STATE, THE MATCHING RATES FOR BENEFITS IN THE AFDC AND MEDICAID PROGRAMS WILL DROP SIGNIFICANTLY. IN MANY CASES THE FEDERAL

GOVERNMENT WILL EFFECTIVELY BE MATCHING STATE DOLLARS AT LESS THAN 50 PERCENT FOR THE AFDC AND MEDICAID PROGRAMS, THEREBY SHIFTING THE BULK OF THE BURDEN FOR MEETING THE BASIC NEEDS OF THE POOR TO THE STATES.

THIS SHIFT IN FINANCIAL RESPONSIBILITY FOR THESE PROGRAMS WILL PROFOUNDLY AFFECT THE STATES' ABILITY TO FUND COST-OF-LIVING INCREASES OR OTHER VITAL SERVICES FOR LOW INCOME PERSONS. THUS, THE EFFECT OF THESE SANCTIONS WOULD BE TO FURTHER REDUCE THE FEDERAL SAFETY NET FOR THE POOR IN REAL TERMS. FOR EXAMPLE, SINCE 1970, REAL MAXIMUM AFDC BENEFITS FOR A 4 PERSON FAMILY DECLINED BY AN AVERAGE 37 PERCENT. FURTHER, THE REAL COMBINED AFDC AND FOOD STAMP BENEFIT LEVELS SINCE 1972 FOR A FAMILY OF FOUR WITH NO INCOME HAS DECLINED BY CLOSE TO 22 PERCENT NATIONWIDE. WHILE THE STATES ARE ATTEMPTING TO COMPENSATE FOR THESE PAST REAL REDUCTIONS--IN DELAWARE WE INCREASED AFDC BENEFITS BY FOUR PERCENT THIS YEAR--FISCAL SANCTIONS WOULD EXACERBATE THIS PROBLEM.

AS A RESULT, THE GOVERNORS STRONGLY SUPPORT CONGRESSIONAL ACTION TO REVISE AND IMPROVE THE QUALITY CONTROL SYSTEMS FOR THE AFDC AND MEDICAID PROGRAMS. WE BELIEVE THAT IT IS IRONIC THAT THE CURRENT QUALITY CONTROL SYSTEMS, MANDATED BY CONGRESS, WILL BEGIN LARGE ERROR RATE SANCTIONS WHEN STATE ERROR RATES ARE AT AN ALL-TIME LOW, THUS DEMONSTRATING THE FUNDAMENTAL

SUCCESS OF QUALITY CONTROL AS A MANAGEMENT SYSTEM. FOR EXAMPLE, IN THE AID TO FAMILIES WITH DEPENDENT CHILDREN PROGRAM, OFFICIAL ERROR RATE DATA SHOWS THAT ERRORS WERE REDUCED TO 6.5 PERCENT BY SEPTEMBER 30, 1983, COMPARED WITH 16.5 PERCENT IN 1973, A REDUCTION OF MORE THAN 60 PERCENT. IN MY OWN STATE OF DELAWARE, WE HAVE BROUGHT OUR ERROR RATE DOWN FROM 16.1 PERCENT IN 1978 TO A STATE-CALCULATED RATE OF 3.75 PERCENT AS OF MARCH, 1985, A 77 PERCENT DECREASE. WE HAVE DONE THIS BY MEANS OF A TOTAL COMMITMENT AT ALL LEVELS TO IMPROVE THE EFFICIENCY AND ACCURACY OF PROGRAM ADMINISTRATION. OUR EFFORTS HAVE INCLUDED DEVELOPMENT OF A STATE-OF-THE-ART COMPUTERIZED ELIGIBILITY SYSTEM (WHICH HAS RECEIVED NATIONAL RECOGNITION), UTILIZATION OF A HIGHLY STRUCTURED CORRECTIVE ACTION PROCESS THAT HAS BEEN PRAISED BY FEDERAL OFFICIALS, A SUPERVISORY REVIEW PROCESS, AND OTHER INNOVATIVE ERROR REDUCTION TECHNIQUES. NEVERTHELESS, IN SPITE OF THESE EFFORTS, DELAWARE IS LIABLE FOR SANCTIONS FROM 1981 ONWARD, AND WILL BE IN 1985 EVEN WITH OUR 3.75% ERROR RATE, IN VIEW OF THE CURRENT TARGET OF 3 PERCENT.

THE QUALITY CONTROL SYSTEM IS USEFUL AS A MANAGEMENT TOOL, BUT CERTAIN ELEMENTS OF IT ARE COUNTERPRODUCTIVE WHEN IT IS USED TO IMPOSE PENALTIES. WE BELIEVE CONGRESS MUST ACT TO RESTORE THE SYSTEM'S USEFULNESS AS THE MANAGEMENT TOOL IT WAS ORIGINALLY DESIGNED TO BE.

THE GOVERNORS ADOPTED A POLICY LAST FEBRUARY URGING CONGRESS TO TAKE IMMEDIATE ACTION THAT WOULD:

- ESTABLISH ERROR RATE TOLERANCE LEVELS BASED ON DEMONSTRATED STATE ACHIEVEMENT. THE CURRENT 3 PERCENT ERROR RATE TOLERANCE IS NOT REASONABLE. DESPITE SUBSTANTIAL INVESTMENT IN CORRECTIVE ACTIONS BY ALL STATES, ONLY 2 STATES HAVE BEEN ABLE TO MEET AND MAINTAIN THE 3 PERCENT TOLERANCE FOR FOUR-SIX MONTH PERIODS IN A ROW FOR 1981-1983.

- MODIFY STATE-BY-STATE TOLERANCE LEVELS TO REFLECT DEMOGRAPHIC AND PROGRAM CHARACTERISTICS WHICH MAY AFFECT PERFORMANCE. THE CURRENT SYSTEM IGNORES THE DIFFERENCES IN COMPLEXITY OF STATE PROGRAM DESIGNS AND THE DIFFERENCES IN THE DEMOGRAPHICS OF THE CASELOAD ACROSS STATES. FOR EXAMPLE, SOME STATES, INCLUDING DELAWARE, PROVIDE AFDC FOR TWO-PARENT FAMILIES WHICH HAVE MORE COMPLEX ELIGIBILITY REQUIREMENTS; AND SOME STATES HAVE MANY MORE RECIPIENT FAMILIES IN THE LABOR FORCE RECEIVING EARNINGS, CASES MORE ERROR PRONE WITH RESPECT TO ELIGIBILITY DETERMINATION AND CORRECT PAYMENT.

o ELIMINATE "TECHNICAL ERRORS" FROM THE OFFICIAL ERROR RATE FOR PURPOSES OF FISCAL SANCTIONS. TECHNICAL ERRORS, SUCH AS PAPERWORK SHOWING RECIPIENTS REGISTERED FOR WORK, ARE ERRORS WHICH HAVE NO DIRECT AFFECT ON THE PAYMENT. THAT IS, WHEN THE ERROR IS CORRECTED, THE PAYMENT REMAINS THE SAME.

o SET THE OFFICIAL ERROR RATE AT THE LOWER BOUND OF THE RANGE OF THE STATISTICAL ESTIMATE. ERROR RATES ARE COMPUTED BASED UPON SAMPLES OF CASES, AND THEREFORE THE RATES ARE STATISTICAL ESTIMATES. THE TRUE ERROR RATE, THEREFORE, IS NOT KNOWN. WE BELIEVE THE LOWER BOUND IS THE "BEST" ESTIMATE BECAUSE IT WILL PROVIDE THE FEDERAL AND STATE GOVERNMENTS A 97.5 PERCENT PROBABILITY THAT THE OFFICIAL ERROR RATE IS NOT AN OVER-ESTIMATE.

o IMPROVE THE TIMELINESS OF ISSUANCE OF OFFICIAL ERROR RATES. HERE WE ARE ALMOST INTO FY 1986 AND THE LATEST OFFICIAL ERROR RATES ARE FOR FY 1983.

o CONSIDER THE COST-EFFECTIVENESS OF ERROR RATE REDUCTION WITHIN THE CONTEXT OF A FAIR SYSTEM OF "GOOD FAITH EFFORT" WAIVERS. WE FIRMLY BELIEVE THAT STATES SHOULD NOT BE REQUIRED TO IMPLEMENT CORRECTIVE ACTIONS

WHICH ARE NOT COST EFFECTIVE AND SHOULD BE PROVIDED WAIVERS OF SANCTIONS ONCE ALL COST-EFFECTIVE CORRECTIVE ACTIONS HAVE BEEN IMPLEMENTED.

- MODIFY THE PROCESS FOR WAIVING FISCAL SANCTIONS TO PROVIDE STATES WITH A FAIR SYSTEM FOR SEEKING GOOD FAITH WAIVERS. FOR EXAMPLE, WAIVERS SHOULD BE PROVIDED WHEN A STATE CAN DEMONSTRATE THAT THE GOOD FAITH EFFORTS MADE HAVE HAD QUANTIFIABLE RESULTS IN THE SAME YEAR OR IN SUBSEQUENT YEARS. DELAWARE'S EXPERIENCE REGARDING ITS 1981 MEDICAID ERROR RATE IS A GOOD CASE EXAMPLE. A MAJOR SOURCE OF ERROR IDENTIFIED DURING THE YEAR WAS PROMPTLY ELIMINATED, AND THE ERROR RATE DROPPED DRAMATICALLY. HOWEVER, THE WAIVER REQUEST WHICH POINTED THIS OUT WAS NOT APPROVED.

WE HAVE SOUGHT CONGRESSIONAL ACTION TO ACHIEVE THESE BASIC REFORMS. WE ARE HAPPY TO REPORT THAT THE WAYS AND MEANS COMMITTEE, AS PART OF ITS DEFICIT REDUCTION PACKAGE PASSED IN COMMITTEE IN JULY, HAS REPORTED OUT AN EXCELLENT SET OF QUALITY CONTROL SYSTEM REFORMS. WE EXPECT THE FULL HOUSE TO PASS THAT PACKAGE SOON.

SENATOR DANIEL EVANS HAS INTRODUCED S.1362 ON WHICH HE TESTIFIED YESTERDAY AND WHICH WE STRONGLY SUPPORT. SENATOR

EVAN'S BILL SEEKS SEVERAL IMMEDIATE REFORMS WHICH ARE BASICALLY CONSISTENT WITH OUR POLICY, SUCH AS A MORE REASONABLE ERROR RATE TOLERANCE AT 4 PERCENT, ELIMINATION OF TECHNICAL ERRORS AND AN OFFICIAL ERROR RATE SET AT THE LOWER BOUND OF THE STATISTICAL ESTIMATE. HIS BILL ALSO CALLS FOR A SYSTEM OF INCENTIVE PAYMENTS TO STATES WITH ERROR RATES BELOW THE FOUR PERCENT TARGET WHICH WE BELIEVE IS ANOTHER REASONABLE REFORM WHICH WILL DO MORE TO HELP REDUCE ERROR RATES THAN FISCAL SANCTIONS.

FOR THE LONGER TERM, SENATOR EVANS' BILL WOULD PROVIDE FOR A MORATORIUM ON FISCAL SANCTIONS UNTIL CONGRESS REFORMS THE QUALITY CONTROL ERROR RATE TOLERANCES BASED UPON CONCURRENT STUDIES BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE NATIONAL ACADEMY OF SCIENCES. IF CONGRESS DECIDES THAT MORE STUDY IS NEEDED BEFORE SETTING FEDERAL TOLERANCE LEVELS, WE BELIEVE THAT A MORATORIUM ON FISCAL SANCTIONS WOULD BE ESSENTIAL. THE TWENTY-ONE STATES CURRENTLY LIABLE FOR FISCAL SANCTIONS FOR FY 1981 WILL BE SEEKING COURT ACTION BASED ON CURRENT LAW IF DENIED A WAIVER AT THE HHS GRANT APPEALS BOARD. IT IS INCUMBENT UPON CONGRESS TO MANDATE A MORATORIUM WHICH WOULD, IN THE SHORT TERM, ELIMINATE THE INEFFICIENT TIME CONSUMING LITIGATION THAT WOULD OTHERWISE GO FORWARD UNDER CURRENT LAW.

In the strongest terms, we urge favorable Committee action on Senator Evans' bill so that we can avoid needless litigation and move toward basic system reforms.

While this hearing is concerned with deficit reduction, we realize that the Committee may also discuss several issues regarding tax reform. As you know, Governor John Carlin of Kansas, then Chairman of NGA, and Governor Richard Lamm of Colorado, lead Governor for tax reform, testified on behalf of NGA on tax reform issues on July 25, 1985 before this Committee. If there are additional areas where the Committee would like more information on NGA's positions, we would be happy to have Governor Lamm respond in writing.

In conclusion, we recognize the Committee's commitment to meet the deficit reduction goals set forth in the budget resolution as a significant step toward reducing federal deficits which are crippling the long run outlook for our economy. We urge that as part of your deficit reduction package you adopt Medicaid and AFDC provisions consistent with the budget resolution and include the Quality Control reform package introduced by Senator Evans and Co-sponsored by 31 senators including six members of the Committee.

Thank you again for the opportunity to testify. We offer our cooperation and support for the measures that, consistent with our budget policy, will effectively reduce the deficit.

The **Chairman**. In your testimony, you make reference to Medicaid home and community-based waiver programs, and every one of us on this committee—I think probably everyone in the Congress—has had some problems. We usually have success, but we have had to argue with HHS about extending waivers.

And we are toying with the idea of giving the States more flexibility in the areas of case management and the services offered, so long as they stay within the financial cap that they have.

What is your judgment on how that would work?

Governor **Castle**. Perhaps for a technical comment, we should call up Thomas Eichler, who is my secretary of health and social services for the State of Delaware.

The **Chairman**. You are welcome to have him come up and join you, if you like.

Governor **Castle**. My response in a more general sense is that we need that exact kind of cooperation between the Federal Government and the States in terms of working out programs.

Just in this case, for example—as we were talking about before this hearing began—when you set a sanction set it in such a way that it is effective but not burdensome to those who are trying to implement it.

And I think the idea of working with different systems and working with some flexibility to make sure these things will eventually be able to be carried out by the States does make a lot of sense.

As to the technical aspects, I would defer to Tom for his comments on that.

The **Chairman**. For the record, could you give Tom's last name, so that they can have it?

Mr. **Eichler**. Thomas Eichler, secretary of health and social services in the State of Delaware.

We are about to file a Medicaid waiver for the very services that you are talking about because of the flexibility that it does allow us.

We have looked at our demographics and we realize that our elderly population is the fastest growing part of our community, and we very much believe that the things that we can do under such a waiver to support our elderly in the community are much more cost effective and constitute better service to them than to strictly providing funding when they have to go into a nursing home.

We think that that kind of flexibility offers us the management attitude and incentives to look at the whole range of services that ought to be provided, so we are very much in favor of that.

The **Chairman**. What we have discovered with the administration, and I can partially sympathize with them, is that any time we use the word "home"—home health, home care, home services—what they see is a brandnew entitlement program of unlimited potential for beneficiaries, and I understand their fears.

As we look back upon Medicaid and Medicare, no one grasped how expensive it was going to be. No one, as we got into it. But if on the other hand we say to a State, look, all you are going to get is $1,000 and you can put a person in a nursing home if you want or you can keep two people at home if you want—if you can do two at home for $1,000, fine.

Why should we care, so long as you only get $1,000, whether you choose to take care of somebody in a hospital, a nursing home, or at home?

Mr. **Eichler**. The discipline that is imposed in the current application process forces us to address those issues and to look at the costs and the options. While the process is very problematic in the experience of many States, I think it does give us an incentive to balance the books and be sure that the costs on balance are actually no more expensive, and hopefully somewhat less expensive.

I think the States do have an interest because we do put money into this as well to keep those costs down.

The **Chairman**. Governor, I asked you this just ahead of the hearing, and this is on the quality-control issue. And I posed the question to you: Would we have gotten the quality control had the Federal Government done nothing?

And I wonder if you would respond to that? And then my second question would be: If we have gotten these costs somewhat under control because of the Federal sanctions or the Federal threats or the Federal pushing, why not continue?

Governor **Castle**. Let me respond to both those things because it gives me a chance to say something that I want to say, too, about what the States are doing.

I think the answer is the States would not have done as well in reducing their error rates without the threat of some sanctions by the Federal Government, and I think that is evident.

Delaware is a good example. We have reduced our error rate by 77 percent. Clearly, that should have been done anyhow.

The other States, on an average, have reduced their error rate by 66 percent. That should have been done anyhow, but I have a hunch, just looking at the bureaucracies of governments in general, that that probably would have been slower if somebody hadn't come in above us and said: "You have got to do it or you are not going to get your money." It tends to make people react.

So, certainly, it has been good, and I don't mean in any way to suggest that the error-rate sanction-type legislation should not be imposed at all. I think that would be an error.

That goes along with my own belief that we should do everything in our power to correct errors in this and anything else that we are doing.

And I also realize that you have one heck of a serious job, as one of the most important persons in the country right now in terms of reducing the deficit, which I happen to believe in totally.

So, we are all looking at these problems to analyze how we can reduce errors and expenditures as a whole, be they State or Federal expenditures.

I believe that the Federal Government has had a lot to do about that, and that is the reason why this has happened.

On the other hand, the States have an interest in this also. We do contribute to many of these programs, almost all the programs ourselves. We want to be error free in terms of just holding ourselves out to the public.

As Tom Eichler and I were talking about before, it is a question of making sure that the rest of the population understands, if we are going to be dealing with welfare and food stamps and programs like this, that there is not cheating going on, as is the common perception by a lot of people in this country in every State—that everybody on welfare is cheating, and it really is undeserved.

We want to eliminate errors. We want to eliminate mistakes. We want to eliminate fraud. And we want to do all those things as rapidly as we can.

I think that we have to get to a point where that is as reduced as far as it can be. However, you get to a certain level—and we aren't sure what that level is—but, as we were also talking about before, you get to the point where it almost isn't worth the cost of finding out if you can squeeze any more out of it.

In other words, getting to the point where we were before—where we were clearly wrong 10 years ago—to the point where we are today in 1985, was relatively simple.

The CHAIRMAN. There is going to be a law of diminishing returns some place. You can't improve your error rate 100 percent, year after year after year.

Governor CASTLE. Exactly, and the question, I think, that we are dealing with here is not whether the Federal Government should be doing anything, but where we should be.

Should we be at 4 percent or some percentage different than the percent which is stated in current law?

I think the feeling is, by those who are experts in the field, and I don't pretend to be such—but representing the other Governors and the people who work in this area—is that this is going too far. This is beyond where the States have gotten.

And that is reflected in the fact that you have over 40 States that may be in danger of error-rate sanction error in the course of a few years. And that, I think, is perhaps carrying the limits a little too far.

So, I think we are really addressing a number of the things that Senator Evans frankly addressed in his legislation, and it is really a question of changing some of those levels around, but keeping the program in effect.

The CHAIRMAN. One last quick question, and you and I are both aware of the dangers of averaging, but you will see this statement: On the average, the States have surpluses. And on the average—but it isn't average on the Federal Government—we know where we are in the Federal Government—where is Delaware?

Governor CASTLE. I am proud to say that Delaware—but maybe I shouldn't be saying it in light of my testimony here—probably has the highest surplus by percentage in the country in this last year. We were third highest on June 1, and I think by the end of June we were probably the highest.

And we have done very well with that, but we have worked like heck to get there. Governor DuPont before me, and I have both made the fiscal controls our paramount weapon in everything that we deal with in the State.

We have imposed constitutional limitations of 98-percent spending limitations. We have done everything we possibly can to cut into programs, to reduce what we are doing in the area.

So, we have done well. But the thing that concerns me, Senator, about that—and I know it is illusory in some degree in terms of States, even more so than the Federal Government, which is bigger and is perhaps more stable—if you have a deficit at the State level, it tends to stay the same, or it is predictable as to how far it will go. States' economies, particularly a State like Delaware where there are 610,000 people and 300,000 people in the work force, are greatly affected by a layoff.

For instance, General Motors will shut down next year for 6 months for a changeover, and that causes 5,000 people to be laid off.

The DuPont Co. had an early retirement program, which turned out to be a super retirement program, and they retired a number of workers in Delaware—I think 2,500 or so—right in our State. And these people could have been earning as much as $500,000 a year before they retired and paying income taxes on it.

And just those little things in a State like Delaware can affect our revenues and budgets a great deal. We can look to be in very good shape one year, which we are in 1985; but you can look back to 1982, when we had to tighten our belts dramatically in the middle of the year—or look to 1986 or 1987 perhaps when that may happen again.

States' economies are very fragile and they tend to move up and down very quickly. And I realize you can look at it in the aggregate and say, well, the States have all this surplus.

I think you will find that the surpluses really are not that great and are subject to being washed away again very quickly.

And I would hope as we deal with these programs, we can think a little more in terms of the longer term—the history of our States as to which way they may go.

The CHAIRMAN. At least from time to time, you have got fluctuations which give you a surplus.

Governor CASTLE. That is correct.

The CHAIRMAN. We don't even have fluctuations to deal with.

Governor CASTLE. Once you got there, perhaps you could retain it. I don't know. That is a correct point, and we do have those fluctuations.

And it is nice right now, but I am not too sure I would hang my hat on that in terms of Federal or State programs, quite frankly.

The CHAIRMAN. Governor, I have no more questions. Thank you very much for coming.

Governor CASTLE. Thank you very much.

The CHAIRMAN. Mr. Eichler, thank you for coming. We appreciate it.

Mr. EICHLER. It is a pleasure to be here.

The CHAIRMAN. Now, if we could have Dr. Davis and Dr. Roehrig? Dr. Davis represents the American Medical Association House of Delegates, and Dr. Roehrig is the president of the American Society of Internal Medicine.

Doctors, I might say to you and to all of the other witnesses who will follow, we do have a 5-minute oral testimony rule in the committee, except for Governors or Cabinet officials or the President if he wanted to come and testify.

We will put your statement in the record in its entirety. I have read all of the statements that were in by last night.

If you could abbreviate your remarks in 5 minutes, we would appreciate it.

STATEMENT OF JAMES E. DAVIS, M.D., SPEAKER, AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES, DURHAM, NC

Dr. Davis. Thank you, Mr. Chairman and Senator Long.

My name is James E. Davis, M.D., and I am a physician in the practice of general surgery in Durham, NC. I am also the speaker of the house of delegates of the American Medical Association.

Accompanying me is Ross Rubin of AMA's Division of Legislative Activities. AMA is pleased to have this opportunity to appear before this committee to present our concerns about proposed budget cuts in the Medicare Program.

AMA opposes continuation of the freeze on Medicare reimbursement and physicians' fees. We support an appropriate increase for Medicare physicians and hospital reimbursement as now provided by law unless the Congress legislates an across-the-board freeze of domestic and defense spending as part of a broad program to reduce the Federal deficit and bring stability to the economy.

Absent such an across-the-board freeze, AMA does not believe it appropriate for Medicare to bear the brunt of efforts to hold the line on governmental spending.

It is imperative to place pending modifications of physician reimbursement in perspective. Last year, you enacted strong measures imposing strict conditions upon physicians, requiring elections by them to choose to enter into participating agreement or not. This election was made by physicians who responded in good faith based on assurances in the law—promises that certain events would occur on October 1, 1985.

These promises could now be abrogated under actions taken by House committees. If the Congress does not fulfill the promises set forth in last year's legislation, physicians justifiably will have no reason to make this year's participation decisions based on expectations that promises contained in new legislation will be carried out.

We urge this committee to reject proposals to continue the physician reimbursement limitations and fee freeze under Medicare.

Continuation of the freeze represents a major step away from accomplishing the goals of the Medicare Program to assure access to and quality care for the Nation's elderly and disabled.

A final rule to reduce reimbursement for teaching hospitals, the direct graduate medical education cost pass through to the level that prevailed during the accounting periods ending in 1984, has been published.

The AMA opposes the reductions in GME funding implemented by Health and Human Services and urges a reversal of the administration's actions.

Many inner city hospitals—teaching hospitals—whose residents provide substantial amounts of care to the poor will be severely affected. In light of current budget restraints, the AMA does support a limit on the number of years that a resident would be supported to the lesser of 5 years or the time necessary to achieve initial board certification.

AMA also supports funding for residents who are graduates of accredited medical schools, either by LCME or the American Osteopathic Association.

The American Medical Association is opposed to mandated second opinions before every elective surgical procedure. Their imposition into the existing patient-physician relationship would have a deleterious effect on that relationship, and it could impose an element of doubt in a patient's mind at the time when that patient is most in need of a strong belief in the views and abilities of his or her physician.

Patients will be better served if the Federal Government encourages such an opinion instead of requiring mandatory second opinions.

Also, the potential for savings for mandating second opinions may be illusory. A July 1 CBO report called estimated savings very uncertain.

The so-called antidumping provision would make it a criminal violation as well as a breach of a Medicare provider agreement if a patient was not provided an appropriate medical screening examination to determine whether an emergency medical condition exists or where there is a so-called inappropriate transfer.

The AMA abhors any inappropriate transfer of patients. We agree with the intent of this provision aimed at eliminating dumping.

However, the heavyhanded approach contained in H.R. 3128 is not appropriate. Under this bill, a physician could be held liable for failure to admit a patient to a hospital in which he or she may not even have admitting privileges.

This issue should be the subject of further study and not immediate legislation.

A provision contained in both H.R. 3101 and H.R. 3128 would allow the Secretary to impose civil penalties and bar a physician from participating in the Medicare Program in situations where the physician knowingly and willfully bills a beneficiary for assistant surgeon services in a cataract operation where there has not been prior approval.

The CHAIRMAN. Doctor, I will have to ask you to conclude.

Dr. DAVIS. Yes, sir. Mr. Chairman, Senator Long, Medicare beneficiaries are truly entitled to high-quality health care services. Budget proposals having an adverse impact on the ability of physicians, hospitals, and others to assure Medicare beneficiaries the quality of services they were promised should not be adopted.

Thank you, sir, for the privilege of appearing.

The CHAIRMAN. Thank you, Dr. Davis. Dr. Roehrig.

[The prepared written statement of Dr. Davis follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Finance
United States Senate

Re: FY 1986 Medicare Budget Reconciliation Proposals

Presented by: James E. Davis, M.D.

September 13, 1985

Mr. Chairman, and Members of the Committee:

My name is James E. Davis, M.D., and I am a physician in the practice of general surgery in Durham, North Carolina. I am also the Speaker of the House of Delegates of the American Medical Association. Accompanying me is Ross Rubin of the AMA's Division of Legislative Activities.

The American Medical Association is pleased to have this opportunity to appear before this Committee to present our concerns over proposed budget cuts in the Medicare program. While some of the Medicare budget proposals for Fiscal Year 1986 advocated by the Administration, the House Ways and Means Committee (H.R. 3128), and the House Energy and Commerce Committee (H.R. 3101) warrant support, many of the proposed cuts being considered continue the practice of the last five years of targeting the Medicare program for an inequitable burden of federal spending reductions.

The American Medical Association appreciates the difficult decisions that this Committee is facing. However, major cuts in Medicare will harm those who can least afford it, erode the quality of health care, jeopardize access to physicians and other providers of health care, and unfairly shift costs to other segments of society. Starting with the Omnibus Budget Reconciliation Act of 1980 through to last year's Deficit Reduction Act, numerous provisions were enacted that have resulted in multi-billion dollar cuts in the Medicare program. Nevertheless, this Congress is once again looking to these vital health programs as sources of major budget savings.

The AMA is strongly committed to real reductions in health care expenditures. In response to an AMA call to all physicians in February 1984, physicians voluntarily agreed to freeze their charges to all patients, not just Medicare beneficiaries, for a one-year period. Compliance with this freeze was substantial, with 63% of all physicians not raising their fees for the entire year that the fee freeze request was in effect. The resulting savings from this voluntary activity was an estimated $3.1 billion dollars that otherwise would have been spent for physicians' services. The voluntary freeze was a significant factor in the recent slow-down in the rate of increase in the cost of physicians' services and in the over-all decrease in the nation's spending rate for health care services.

Even though the one-year voluntary fee freeze period has expired, the AMA continues to urge physicians to consider each patient's financial needs when setting charges and to accept Medicare assignment, reduce fees, or charge no fee at all in financial hardship cases.

The AMA opposes continuation of the freeze on Medicare reimbursement and physician fees. We support an appropriate increase for Medicare physician and hospital reimbursement as now provided by law, unless the Congress legislates an across-the-board freeze of domestic and defense spending as part of a broad program to reduce the federal deficit and bring stability to the economy. Absent such an across-the-board freeze, the AMA does not believe it appropriate for Medicare to bear the brunt of efforts to hold the line on governmental spending.

NEW REVENUE SOURCES

Additional sources of revenue should be used to avoid further cuts in important health care programs. Specifically, we support an increase in the cigarette tax to 32¢ per package to generate total revenue of at least $6.5 billion annually. We testified on this issue before the Taxation and Debt Management Subcommittee on September 10. We also support an increase in the tax on alcoholic beverages. The revenues raised through the increase in these taxes should go to the Medicare trust funds and greatly diminish the need for continued cuts. This action would not only relieve pressures on the budget but would discourage use of alcohol and tobacco and assist in achieving public health goals.

PHYSICIAN REIMBURSEMENT UNDER THE MEDICARE PROGRAM

It is imperative to place pending modifications in physician reimbursement in perspective. Last year you enacted strong measures imposing strict conditions upon physicians, requiring elections by them to be "participating" or "non-participating." This election was made by physicians who responded in good faith based on assurances in the law -- "promises" -- that certain events would occur on October 1, 1985. These promises now could be abrogated under actions taken by House committees.

Mr. Chairman, if the Congress does not fulfill the promises set forth in last year's legislation, physicians justifiably will have no reason to make this year's participation decisions based on expectations that "promises" contained in new legislation will be carried out. Not only is this feature a stumbling block for physicians as they seek to cooperate, but there are many other problems inherent in the Congressional considerations.

Consider the situation of physicians who are being asked to make a participation election within the next seventeen days. Answers are needed to the following questions: Can a physician make an informed choice that will govern his or her practice for the next year based on existing law and the "promises" it contained? Will proposed changes now under consideration by Congress materially impact on the decision-making process? If further promises are made to future participating physicians, will they be honored or dishonored? It is obvious that, even with the lack of information needed to make informed decisions, physicians nevertheless are compelled to make participation elections -- increasing skepticism about the merits of cooperation.

Participation — Non-Participation

The perception created by statute that there are separate classes of physicians providing care under the Medicare program should be clarified. While Medicare now recognizes "participating" and "non-participating" physicians, in reality both groups of physicians are encouraged to provide care for Medicare beneficiaries. In some situations there is no difference between physicians in these two categories other than the label. While "participating physicians" are identified as accepting assignment on 100% of all claims, there are "non-participating physicians" who also accept 100% of their Medicare claims on an assigned basis. Indeed, 23% of the physicians who had accepted 100% of their claims on an assigned basis prior to the inception of the "participating physician" program did not elect to "participate" under the new law. As a matter of fact, over 69% of all Medicare claims are accepted under assignment, although only 30% of physicians elected the participating status.

Continuation of the Reimbursement Limitations and Fee Freeze

The American Medical Association is opposed to a continuation of the freeze on physician reimbursement and fees under Medicare. In the last Congressional budget cycle, the only freeze imposed was placed on physicians. Continuation of this 15-month freeze would extend an unfair and extremely discriminatory practice. Other elements of the economy are not being asked to undergo similar restraints in payment from the federal government. A one-year extension of the freeze would be particularly discriminatory as only physicians would be subjected to a 27-month freeze.

Under the Deficit Reduction Act of last year, the increase in the Medicare prevailing rate scheduled for July 1, 1984 was eliminated, and the July 1, 1985 increase was postponed until October 1, 1985. A further postponement of one year will mean that there would be no allowed increase from July 1, 1983 through September 30, 1986 -- a 39-month freeze. Moreover, because of Medicare's payment structure, reimbursement for most of 1986 will be based on 1982 charges.

The proposal to continue the freeze for an additional year will unduly extend the existing lengthy time lag in reflecting changes in reimbursement. This proposed action will have a number of negative results and prove to be counterproductive. It will not only discourage physicians from accepting assignment, it may discourage physicians from treating Medicare beneficiaries. For those physicians who continue to treat Medicare beneficiaries, their ability to acquire new equipment and adopt new technologies and to meet increased costs, including the increasing costs of professional liability insurance, will be reduced.

Selective Increases in Reimbursement are Inappropriate

As a part of the Deficit Reduction Act, all physicians were promised an increase in the Medicare reimbursement rate on October 1, 1985. Some proposals, however, would grant only the "participating physicians" an increase in reimbursement under Medicare. Such a selective action is neither fair nor appropriate. "Participating physicians" were given favorable treatment under the Deficit Reduction Act inasmuch as their fee profiles were to reflect increases in their fees made during the current fifteen month freeze. Allowing an increase in reimbursement for only "participating physicians" would perpetuate and aggravate the current discrimination in the law. An equal increase should be provided to all physicians so that the value of Medicare coverage will not be eroded for those beneficiaries who freely choose to receive their medical care from "non-participating physicians."

Continuation of the Fee Freeze and Reimbursement Limits is Inequitable

A continuation of the fee freeze and reimbursement limitations will work particularly severe hardships on physicians and their patients in situations where the physicians' fees have been frozen at a relatively low charge level, and where physicians did not increase their fees during the AMA's voluntary fee freeze. These physicians will be penalized for their good faith effort to hold the line on health care expenditures.

Provider-based physicians will also be hard hit, particularly those who had been reimbursed through a combined billing process prior to October 1, 1983, and did not have a customary charge profile in effect when the fee freeze was instituted. Their interim profiles, pending the determination of actual customary charges, were set according to "compensation-related customary charges." Because the Deficit Reduction Act prevented any redetermination of customary charge profiles, these physicians were frozen at a charge level that in many instances is dramatically below the customary and prevailing charge in the community for similar services. (A provision to address this problem is included in both H.R. 3101 and H.R. 3128 and the AMA supports adoption of such a provision.)

Acceptance of Assignment

A continuation of the Medicare reimbursement limitations and the fee freeze will discourage physicians from accepting Medicare claims on an assigned basis. This could reverse the current trend of continually increasing rates of acceptance of assignment. The ability of physicians to accept assignment on a claim-by-claim basis is an important element of

Medicare that assures beneficiaries access to virtually any physician. The history of physician acceptance of assignment bears out the fact that physicians do recognize the financial needs of their elderly and disabled patients and that they do accept assignment where warranted.

Continuing a trend started in 1976, the rate of assignment of all claims has increased from 50.5% in 1976 to 69.3% in May of this year. Clearly, we are at a point where those Medicare beneficiaries in need of health care services at reduced fees readily should be able to find a physician who will accept Medicare assignment.

Proposals under Consideration by the House of Representatives

H.R. 3101 and H.R. 3128 both have provisions that would extend the fee freeze and Medicare reimbursement limitations and create new conditions with a substantial impact on participation elections. These provisions would violate the promise of the 98th Congress by not allowing a full economic index increase in Medicare reimbursement for all physicians. In addition, the Ways and Means bill even further penalizes currently participating physicians, i.e., those who elect not to participate during FY86, along with non-participators by totally denying them any increase in Medicare reimbursement.

H.R. 3128 also adds a number of so-called participation "incentives" that we believe should not be adopted. It would eliminate the "PARL" directory that lists the assignment rate of all physicians, and it would modify the Explanation of Medicare Benefits (EOMB) form to inform beneficiaries of the option to obtain care from a "participating physician." The elimination of the PARL would deny valuable information to beneficiaries which could enable them to ascertain the likelihood of assignment acceptance by a "non-participating physician." It would also impact negatively on those physicians who historically have taken a high percentage of claims on an assigned basis and who have elected not to be a "participating physician." The modification of the EOMB form may be misleading since it implies that Medicare endorses receipt of care through a "participating physician."

Mr. Chairman, the American Medical Association urges this Committee to reject proposals to continue the physician reimbursement limitations and fee freeze under Medicare. Continuation of the freeze represents a major step away from accomplishing the goals of the Medicare program to assure access to and quality care for the nation's elderly and disabled.

FREEZING PAYMENT RATES TO HOSPITALS

The AMA is also opposed to the proposed freeze in hospital reimbursement for services provided Medicare beneficiaries. The imposition of such a freeze mid-way through the phase-in process of the prospective pricing system (PPS) would be particularly damaging to the quality of health care services.

A recent report by the General Accounting Office (GAO) raises substantial concerns about discharges of patients in poorer health status than prior to implementation of PPS. We strongly believe that, until concerns raised in the GAO report and in hearings held earlier this year are answered, a freeze on the prospective payment rate will aggravate the identified problems.

Disproportionate Share Hospitals

The American Medical Association is also concerned that hospitals serving a disproportionate share of indigent patients or Medicare beneficiaries are not properly recognized by HHS. When the PPS was enacted, it directed that "the Secretary shall provide for such exceptions and adjustments to the payment amounts ... to take into account the special needs of ... public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under Part A of this title." The Secretary has yet to fulfill this requirement, and this delay should not be allowed to continue.

H.R. 3128 would require the Secretary to make the disproportionate share payments only to urban hospitals with over 100 beds that serve a disproportionate share of low income patients. While we support a payment adjustment for the hospitals that would be covered by this provision, we believe that it should be expanded to encompass all affected hospitals as envisioned by the Congress in passing the PPS legislation. Such an adjustment is appropriate as both the Medicare and Medicaid programs provide coverage for hospital services at a discounted rate in comparison with private coverage.

MEDICARE REIMBURSEMENT FOR GRADUATE MEDICAL EDUCATION

The Administration's fiscal year 1986 budget proposes to reduce Medicare reimbursement for teaching hospitals' direct graduate medical education (GME) costs to the levels that prevailed during hospital accounting periods ending in calendar year 1984. The Administration has published a Final Rule to this effect. The President's budget also would cut indirect medical education payments by 50%. In addition, there are numerous proposals before Congress to modify Medicare payments for GME.

The AMA opposes the reductions in GME funding implemented by HHS and urges this Committee to reverse the Administration's action. We are particularly concerned over and opposed to the proposed 50% cut in indirect medical education costs and the recently finalized regulatory requirement that prohibits hospitals from counting resident physicians working in attached outpatient departments. (This resident census now is used in formulating the indirect GME adjustment for teaching hospitals.) Many inner-city teaching hospitals whose residents provide substantial amounts of care to the poor would be severely affected, and the failure to count residents in outpatient departments is contrary to efforts to move care to outpatient settings. It also is premature to alter hospital reimbursement until sufficient data is available concerning the impact of the recently implemented PPS that is still in its phase-in stage. This is particularly true in light of a fundamental flaw in the DRG system -- the failure to reflect severity of illness and case-mix differentials.

Changes in direct GME funding may be made in line with the following:

- opposition to a freeze on direct GME costs unless it is part of an across-the-board freeze on all domestic and defense spending;
- support for limiting the number of residency years reimbursed by Medicare (the lesser of first eligibility for certification or 5 years) as long as proper assurances are given that adequate funding will be available for residents in training programs that extend beyond the limit; and
- support for limiting Medicare funding to graduates of accredited medical schools (LCME and AOA). Other sources should be utilized to fund residency training for foreign students who are to return to their native country to practice medicine. Provision should be made to ensure an orderly transition for hospitals that rely on FMGs to meet patient care needs.

The AMA believes that an indepth study of the financing of graduate medical education should be undertaken before Congress considers further changes. To this end, the AMA is preparing a report on GME financing that should be completed by the end of the year.

MANDATED SECOND OPINIONS FOR SURGERY

H.R. 3101 would create a mandatory second surgical opinion program (SSOP) for Medicare beneficiaries. The AMA recognizes that the advisability of surgery or other specific therapy can be a matter of opinion; however, we do not support mandating second opinions. The American Medical Association: (1) reaffirms the right of the patient or a physician to seek a second opinion freely from any physician of choice; (2) opposes the concept of mandatory second opinions or the imposition of financial penalties by a third party payor for not obtaining a second opinion; and (3) supports the concept that when a second opinion is required by a third party that second opinion should be at no cost to the patient.

Voluntary second opinions for elective surgery are valuable for both the physician and the patient. Where either party voluntarily solicits a second opinion, the second opinion can help in establishing a course of treatment. Also, such an opinion may have the effect of saving money if it presents an alternative course of treatment which proves to be less expensive than the surgery initially considered. Finally, a second opinion can encourage a patient to have needed surgery when the patient might have reservations concerning the surgery or initially chooses against the surgery recommended by the first physician.

The AMA is opposed to mandated second opinions before every elective surgical procedure. Their imposition into the existing patient/physician relationship could have a deleterious effect on that relationship and it could impose an element of doubt in a patient's mind at a time when that patient is most in need of a strong belief in the views and abilities of his or her physician. We believe patients will be better served if the federal government encourages second opinions instead of requiring mandatory second opinions.

We also note that the potential for savings from mandating second opinions may be illusory. A July 1 report from the Congressional Budget Office called estimated savings "very uncertain." The report went on to state:

> Because no study has been done of the reductions in surgery rates in Medicare (or among the aged population) as a result of a mandatory SSOP, the SSOP's effects are largely speculative. It is possible that the costs of a SSOP could exceed any savings or that savings could be even higher than our estimates.

EMERGENCY RESPONSIBILITIES

A provision, known as the "anti-dumping provision," is contained in H.R. 3128 and is directed at services provided in the hospital emergency department. The anti-dumping proposal would make it a criminal offense and violation of a Medicare provider agreement if a patient, whether a Medicare beneficiary or not, was not provided "an appropriate medical screening examination" to determine whether an emergency medical condition exists or if the person is in active labor. Hospitals failing to meet this requirement could be denied participation in the Medicare program and be subject to civil penalties and private civil actions. "Responsible physicians" who either knowingly fail to meet the screening requirements or where the screening is conducted in an "inappropriate" manner would be subject to civil penalties and up to 5 years imprisonment.

The American Medical Association abhors any inappropriate transfer of patients. We agree with the intent of this provision aimed at eliminating "dumping." However, the heavy-handed approach contained in H.R. 3128 is not appropriate. Under this bill, a physician could be held liable for failure to admit a patient to a hospital in which he or she may not even have admitting privileges. (Emergency physicians frequently do not have admitting privileges in hospitals where they provide emergency services.) This result could arise as an emergency physician could be deemed the "responsible physician," and such physicians are often dependent on other physicians with admitting privileges at the hospital.

This issue should be the subject of further study and not immediate legislation. The imposition of criminal sanctions and penalties will not resolve the health care problems of the poor. Congress should address the reasons for existing transfers and provide adequate resources to treat the medical needs of the indigent.

EXPANDED COVERAGE FOR THE SERVICES OF OPTOMETRISTS

The Medicare program currently authorizes coverage for optometric services only "with respect to services related to the condition of aphakia." H.R. 3101 would expand optometric coverage to include all currently covered services where an optometrist is authorized to perform that service by the state in which he or she practices.

The AMA is concerned with adding expenses to the Medicare program at a time when efforts are underway to find ways to limit the program's expenses. The possible extent of such additional expenditures was detailed in a report submitted to Congress by the Secretary of HHS in 1982. The report says that "the costs associated with even a limited benefit expansion would be difficult to justify in the present economic climate." The following chart from the December 6, 1982, report represents the HCFA estimates of potential Medicare costs for coverage of optometrists' services:

Fiscal Year	Services Related to Cataracts*	Other Services*	Total*
1983	$20	$ 80	$100
1984	30	100	130
1985	30	120	150
1986	40	130	170
1987	50	140	190

*Figures in millions of dollars.

In our view, there is no need for this expansion.

ADMINISTRATIVE AND JUDICIAL REVIEW OF MEDICARE PART B DETERMINATIONS

Legislation recently introduced in both the House and the Senate and a provision of H.R. 3101 would authorize both administrative and judicial review of benefit determinations made under Part B of Medicare. While the Medicare law has always authorized appeals over determinations made under Part A, such appeals have not been allowed under Part B. This long-standing inequity in the law should be corrected. It has worked to the prejudice of claimants, physicians and other health care providers of covered services.

Since a Medicare beneficiary has no right to appeal a denial of benefits for Part B services, this inequity can result in having no recourse when benefits are curtailed. We support adoption of Part B appeal provisions.

ASSISTANT SURGEONS' FEES FOR CATARACT OPERATIONS

A provision contained in both H.R. 3101 and H.R. 3128 would prohibit Medicare reimbursement for assistant surgeons' charges in connection with cataract operations, unless there is prior approval from a PRO concerning the "existence of complicating medical condition." The Secretary could impose civil monetary penalties and assessments and bar a physician from participation in the Medicare program for up to five years in situations where the physician knowingly and willfully bills a Medicare beneficiary for assistant surgeon services where there has not been prior approval. The provision also requires the Secretary to report to Congress with recommendations and guidelines on other surgical procedures for which an assistant surgeon is generally not "medically necessary."

The AMA does not believe that the Medicare program should be responsible for providing reimbursement for services that are not medically necessary. Medicare carriers, working in conjunction with PROs, currently can deny reimbursement in such situations. However, we believe it is inappropriate for Medicare to impose sanctions for the provision of services merely because Medicare will not recognize them as a covered benefit. This situation becomes more important in view of the expected expansion that will affect other services. In any event, there must remain sufficient recognition for the individual circumstances in each specific surgical encounter where assistant services may be necessary. We are opposed to the enactment of this provision contained in H.R. 3101 and H.R. 3128.

INHERENT REASONABLENESS

H.R. 3101 and H.R. 3128 would require the Secretary to establish regulations to specify factors to be used in determining the application of "inherent reasonableness" in setting upper and lower limits on Part B payments. In our view this provision is too broad and subject to potential abuse.

We are concerned that the incorporation of such a provision in a reconciliation bill will give the mistaken impression that Congress intends for physician reimbursement to be modified in all situations regardless of the customary and prevailing charges. We do not believe that this would be appropriate. It would be unfortunate if adoption of this provision would result in arbitrary applications of "inherent reasonableness" or an alteration in the basic methodology for determining Medicare reimbursement levels.

ADDITIONAL PROVISIONS OF H.R. 3101 AND H.R. 3128

The American Medical Association supports additional provisions contained in H.R. 3101 and H.R. 3128 that will benefit Medicare and

Medicaid beneficiaries as well as work to assure the solvency of the Medicare program. Accordingly, we

> support the provision contained in H.R. 3128 calling for preventive services demonstration projects. However, this provision should be modified to authorize the demonstrations to be conducted by schools of medicine. Such a modification would be in keeping with the reality that the services included within the demonstration generally are medical services provided by physicians. Medical schools are appropriate entities to carry out such a demonstration.
>
> support the provision in H.R. 3128 that would allow Medicare coverage for newly hired state and local government employees who would be required to contribute to the Medicare program.
>
> support the intent of the provision in H.R. 3128 calling for continued employer-based health insurance for Medicare ineligible, widowed or divorced spouses and their dependent children with the full premium being paid by the individual.
>
> support the provision of H.R. 3101 that appropriately expands Medicaid coverage for pregnant women to include such women in intact families where the family meets income and resource requirements.

REIMBURSEMENT FOR AMBULATORY SURGERY

A bill recently introduced in the Senate, S. 1489, would establish a maximum reimbursement rate for facility services when surgical procedures are provided in an ambulatory surgical center (ASC) and a hospital outpatient department. This maximum reimbursement rate would be capped at the DRG payment rate for the same surgical procedure when provided on an inpatient basis in a hospital in the same area (it would not include physicians' services). The proposal would prohibit many states, those with agreements to certify eligibility of facilities, from requiring compliance with their requirements for certificate of need, licensure, and other regulatory requirements in situations where those requirements are not imposed on "similar entities" not seeking to qualify as an ASC under the Medicare program. The bill also would expand PRO authority to require PRO review of ambulatory surgical procedures provided Medicare beneficiaries in an ASC and a hospital outpatient department. It authorizes the Secretary to limit this review to a statistical sample of selected procedures.

The American Medical Association supports the intent of S. 1489. It usually is not appropriate for the facility to charge for a service provided in an ASC or hospital outpatient department in excess of the DRG payment rate when the same service is provided on an inpatient basis. In supporting a cap on such payment rates, however, we must raise a number of concerns about using the DRG payment level as the limiting factor in all cases. Questions have been raised about the adequacy of the DRG rate in a number of situations, and we do not believe it would be right to use the DRG rate as a cap if the DRG rate indeed does not most appropriately reflect actual costs. Also, some anesthesia related charges have been excluded from the DRG payment rate, and this should be recognized in setting the cap on ASC and hospital outpatient facility rates.

The AMA is concerned with certain provisions of this bill. We do not believe it appropriate for Medicare, under the section amended by S. 1489, to preempt the licensure activities of the state -- activities most appropriately left at the state level.

The AMA also questions the expansion of PRO authority into the realm of services provided by ASCs and hospital outpatient departments at this time. While peer review should take place in such settings, we question whether the PRO program is prepared to take on this responsibility or adequately funded to meet this new task. This is of particular concern as the proposal would require 100% review with the Secretary merely given the discretion to limit this review. We recommend that PRO authority to review such care not be implemented at this time. However, if such review is to be started, we believe it should be done only on a limited demonstration basis and that adequate funds be allocated for such an activity. Also, where this review takes place, this review should be done on a focused basis, unless the focused review indicates a need for more intensive review.

DELAY IN THE INITIAL DATE OF ELIGIBILITY FOR MEDICARE

Under existing law, a person is ordinarily covered by Medicare on the first day of the month in which he or she reaches the age of 65. The Administration's budget proposes that eligibility for Medicare be deferred to the first day of the month following an individual's 65th birthday.

In recognition of the fact that there is a need to achieve budget savings in the Medicare program, the Association supports this proposal. Such a modification in the date of eligibility for Medicare benefits should not result in Medicare beneficiaries facing uncovered costs as most existing health insurance policies provide coverage until the date when Medicare coverage begins.

MEDICARE AS SECONDARY PAYOR FOR WORKING BENEFICIARIES OVER AGE 69

The Medicare program currently provides that working beneficiaries and their spouses up to age 69 have the option of keeping employment-based health insurance as primary health care coverage, with the Medicare program providing secondary coverage. The new proposal would extend this option for Medicare beneficiaries over age 69.

The AMA supports this proposal. The ability to maintain health care coverage under an employment-based policy will provide continuity of care. Also, as such an extension is optional for the Medicare beneficiary, individuals will not lose any of their rights under this proposal.

INCREASING THE PART B PREMIUM AND DEDUCTIBLES

The Administration's proposed budget calls for gradual increases in the Part B premium so that it will cover 35% of Part B program costs by 1990. In addition, the proposal calls for increasing the Part B deductible based on the rate of increase in the Medicare economic index.

The AMA supports increasing the Part B premium and deductible to cover 35% of total program costs. Such an action is in keeping with the original intent of the Medicare program. Originally, the program was to be funded one-half by general revenues; however, general revenues now fund approximately three-fourths of the Medicare Part B program.

Medicare, like insurance programs, should have appropriate front-end copayments and deductibles. We recommend, however, that rather than tying the indexing of the Part B deductible to the Medicare economic index, this deductible should be tied to the medical care component of the Consumer Price Index to reflect more accurately changes in the costs of medical services. Also, increases in the Part B premium and deductible should be structured to reflect financial resources of Medicare beneficiaries.

COPAYMENTS FOR HOME HEALTH VISITS

The Administration's budget proposal calls for copayments for home health visits after the first 20 such visits. These copayments would be equal to one percent of the hospital deductible.

The AMA supports this proposal which would encourage appropriate consumer awareness of health care costs. We believe that reasonable coinsurance amounts will not deter beneficial usage of this valuable health care service. In addition, the fact that the copayment would not be applied to the first 20 home health visits will assure that individuals will not be deterred from early utilization of a health benefit that in many instances can prevent the need for costlier services at a later date.

ALTERNATIVE PHYSICIAN PAYMENT METHODOLOGIES

The AMA supports research and demonstration projects to examine various methodologies for physician reimbursement. Such projects and studies would be helpful in determining a fair and successful modification in how physicians are paid for their Medicare covered services. Without adequate study, rapid modification in payment could be detrimental to the goals of achieving health care services of high quality and continued improvement in overall health status for elderly and disabled patients.

The AMA fully supports a pluralistic approach to payment for physician services. We believe that an indemnity payment system should be viewed as a preferred policy for setting physician reimbursement.

Physician Payments Based on Diagnosis Related Groups (DRG)

One methodology for physician reimbursement being studied is to base payment on a fixed cost based on the patient's diagnosis. This concept is the focus of a Congressionally-mandated study by HHS. This study was due by July 1 of this year, but it has yet to be released.

Just as we have continuing concerns over the hospital DRG payment program, we have strong concerns with a DRG-based physician payment plan. A DRG system inherently gives substantial incentives to provide minimal care. It also fails to take into account severity of illness. This is especially troublesome for those physicians who because of specialized skill and training see patients with the most severe illnesses. Since the DRG methodology is based on "averages" and (unlike hospitals) individual physicians do not ordinarily have a large enough patient population with identical diagnoses to enable costs to be spread over a larger base, a DRG system could operate as a disincentive for physicians to accept critically ill Medicare patients and could discourage necessary use of consultants.

We are also concerned about a program where all services to hospital inpatients would be based on DRGs and payment would be made through the hospital. It is evident that if both hospital and physician payments are based on a predetermined amount, all of the economic incentives will be strongly directed toward under-provision of care.

Perhaps the most serious drawback to a DRG-based payment system is that it would break down the role of the physician as the health care advocate for the patient. We never want to see the day when the "best" physician (as designated by Medicare) would be said to be the one who was the least expensive as opposed to the one who provided the best care. Because of its strong potential for adverse effects on patient care, we would object to a DRG system in the absence of proven demonstrations.

Relative Value Studies

The AMA is working with Harvard University in seeking a contract from HCFA for the development of a relative value study (RVS) to establish resource cost based relative values for physician services. We hope that this Committee will work to assure the appropriation of the funds necessary to carry out this important analysis, regardless of which entity would be rewarded such a contract.

A reimbursement system based on a resource cost based relative value study could ameliorate problems inherent in current Medicare reimbursement, and it could allow for greater competition among physicians by allowing patients a greater understanding of charges made for each service. Such a system could also address inequities in payment rates for services that are predominantly cognitive in nature.

CONCLUSION

Medicare beneficiaries are entitled to high quality health care services. Budget proposals having an adverse impact on the ability of physicians, hospitals and others to assure Medicare beneficiaries the quality of services they were promised should not be adopted.

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STATEMENT OF C. BURNS ROEHRIG, M.D., PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE, BOSTON, MA

Dr. ROEHRIG. Thank you, Mr. Chairman.

My name is C. Burns Roehrig, M.D. I am an internist in private practice in Boston, MA, and am serving as president of the American Society of Internal Medicine.

With me is Mr. Robert Doherty of the ASIM staff, who is director of medical services and government affairs.

ASIM strongly opposes extension of the Medicare fee freeze because we are convinced that this proposal, if enacted by Congress, will be to the detriment of Medicare patients.

A recent survey of ASIM members provides clear evidence that if Congress extends the freeze for another year, physicians will find it increasingly difficult to provide patients who are Medicare beneficiaries the same high quality of care that has been the tradition for this program.

This just may not be possible if fees in 1986 are limited to those established in 1982 or earlier. From 1982 to 1983 alone, internists' overhead costs increased by 15.4 percent.

The Congressional Budget Office has projected that the Consumer Price Index will have increased at a cumulative rate of 17 percent from June 1982 through December 1986.

As costs continue to rise, physicians will have little choice but to curtail services, layoff staff, cost shift to non-Medicare patients, or decrease the acceptance of assignment.

ASIM is also concerned that extension of the freeze will break the promise Congress made last year to end the freeze on October 1, 1985.

It would be unfortunate if Congress broke its promise to the medical profession when physicians have honored their commitment to remain sensitive to their patients' financial needs, despite the economic burdens imposed by the current freeze.

This commitment is evidenced by the fact that many physicians voluntarily froze their fees, beginning in 1983, and that acceptance of assignment has increased to approximately 70 percent of all claims in 1985, due in large part to increased acceptance of assignment by nonparticipating physicians.

A concern for fairness dictates that all physicians, both participating and nonparticipating, should have their efforts recognized by Congress.

ASIM recognizes that in attempting to reduce the Federal deficit, Congress may decide to continue some kind of freeze on Medicare allowances.

If this happens, the Society urges the Senate Finance Committee to adopt an alternative proposal that has been supported by both the American Association of Retired Persons and the American Medical Association.

It also appears to have considerable support among your colleagues in the House of Representatives, where it was originally included in the chairman's proposals to the Energy and Commerce Committees Subcommittee on Health and was offered as an amendment to the full committee.

This alternative would increase customary and prevailing charges on October 1, 1985 to the level permitted under current law for these specific services: Primary care services, defined as office visits, home visits, and nursing home visits, of both participating and nonparticipating physicians, and nonprimary care services of participating physicians only.

Customary prevailing and actual charges would continue to be frozen for nonprimary care services of nonparticipating physicians for an additional year.

Nonparticipating physicians would be allowed to increase their actual charges for primary care services by no more than the percentage increase in prevailing charges for those services that would be granted on October 1 under current law.

This proposal would provide some relief from the fee freeze for those high overhead office-based services provided by physicians in virtually all specialties, and by doing so, will help minimize the likelihood that an extension of the freeze will lower the availability and quality of care provided to Medicare beneficiaries.

It would partially keep Congress' promise made last year to both participating and nonparticipating physicians to end the freeze on October 1, 1985. Moreover, it would begin to address some of the inequities in the current reimbursement system between physicians' cognitive services such as office, nursing home, and home visits and the more technologically oriented services.

In conclusion, ASIM strongly urges the committee to oppose an across-the-board extension of the fee freeze. If some extension is approved, we urge you to consider this alternative.

ASIM's written statement for the record includes additional recommendations on other budget proposals affecting health.

I would be pleased to try to answer any questions.

The CHAIRMAN. Dr. Roehrig, thank you.

[The prepared written statement of Dr. Roehrig follows:]

TESTIMONY
OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE
TO THE
SENATE FINANCE COMMITTEE
ON THE
FY 1986 BUDGET

SEPTEMBER 13, 1985

Thank you, Mr. Chairman. My name is C. Burns Roehrig, MD. I am an internist in private practice in Boston, Massachusetts, and president of the American Society of Internal Medicine (ASIM). In spite of organizational commitments such as responding to your invitation to testify before this Committee, I spend the majority of my time in the one-on-one practice of internal medicine.

Freeze on Medicare Payments for Physician Services

ASIM strongly opposes extension of the Medicare fee freeze, because we are convinced that this proposal, if enacted by Congress, will be to the detriment of Medicare patients.

A recent survey of ASIM members provides strong evidence that if Congress extends the freeze for another year, physicians will find it increasingly difficult to provide patients who are Medicare beneficiaries the same high quality of care that has been the tradition for this program. Despite our continued commitment to our patients, this may not be possible if fees in 1986 are limited to those established in 1982 or earlier. From 1982 to 1983 alone, internists' average overhead costs increased by 15.4%; the Congressional Budget Office has projected that the Consumer Price Index will have increased at a cumulative rate of 17% from July 1982 through December 1986. As costs continue to rise, physicians responding to our survey suggested that they will have little choice but to curtail services, lay off staff, cost shift to non-Medicare patients, or decrease acceptance of assignment.

ASIM is also concerned that extension of the freeze will break the promise Congress made last year to end the freeze on October 1, 1985. When the House-Senate conference committee reported the freeze provision last year, it specifically stated that "the provision adopted by the Conferees freezes Medicare customary and prevailing charges for all physicians' services beginning on July 1, 1984, and ending on September 30, 1985. Subsequent fee screen updates would occur on October 1 of each year."

It would be extremely unfortunate if Congress broke its promise to the medical profession, particularly given the fact that physicians have honored their commitments to remain sensitive to their patients' financial needs, despite the economic burdens imposed by the current freeze. This commitment to their patients is evidenced by the fact that many physicians voluntarily froze their fees beginning in 1983 and that acceptance of assignment has increased to approximately 70% of all claims in 1985, due in large part to increased acceptance of assignment by non-participating physicians. Therefore, a concern for fairness dictates that all physicians--both participating and non-participating--should have their efforts recognized by Congress.

ASIM recognizes, however, that in attempting to reduce the federal deficit, Congress may decide to continue some kind of freeze on Medicare allowances. If this is the case, the Society strongly urges the Senate Finance Committee to adopt an alternative proposal that has been supported by both the American Association of Retired Persons and the American Medical Association. It also appears to have considerable support among your colleagues in the House of Representatives, as evidenced by the fact that it was originally included in the chairman's proposals to the Energy and Commerce Committee's Subcommittee on

Health, and was given serious consideration when it was offered as an amendment in the full committee.

Specifically, this alternative would increase customary and prevailing charges on October 1, 1985, to the level permitted under current law for:

- o primary care services, defined as office visits, home visits, and nursing home visits, of both participating and non-participating physicians.

- o non-primary care services of participating physicians only.

Customary, prevailing and actual charges would continue to be frozen for non-primary care services of non-participating physicians for an additional year.

Non-participating physicians would be allowed to increase their actual charges for primary care services by no more than the October 1, 1985, percentage increase in prevailing charges for those services that would be granted under current law.

The CBO has estimated that this proposal would save $640 million over three years. Additional savings would accrue if primary care services were defined more narrowly, such as limiting the increase in allowances to office visits only.

This proposal would provide some relief from the fee freeze for those high overhead office-based services provided by physicians in virtually all specialties, and by doing so, will help minimize the likelihood that an extension of the freeze will lower the availability and quality of care provided to Medicare beneficiaries. It would also partially keep Congress' promise made last year to both participating and non-participating physicians to end the freeze on October 1, 1985. It would also begin to address some of the inequities in the current reimbursement system between physicians' cognitive services, such as office, nursing, and home visits, and more technologically oriented services.

In conclusion, ASIM strongly urges the Committee to oppose an across-the-board extension of the fee freeze. If some extension is approved, we strongly urge you to consider this alternative.

Freeze on Hospital Payments

ASIM is concerned that the administration's decision to freeze hospital prospective payments will adversely affect the quality of patient care. Hospitals and physicians are already responding to the incentives built into the prospective pricing system to be more cost effective by dramatically reducing hospital admissions and length of stay and by shifting care to the outpatient setting. ASIM believes, however, that the proposed cuts in reimbursement are premature and could result in hospitals cutting or even eliminating essential services in order to meet their costs, particularly in view of recent evidence that the current DRG payment levels in some instances may be lowering the quality of care provided to Medicare patients.

A recent study by the General Accounting Office found several alarming trends resulting from implementation of PPS, specifically:

- Patients are being discharged from hospitals after shorter lengths of stay and in poorer states of health than prior to DRGs.

- It is not clear that post-hospital providers--including nursing homes, home and community health services--are equipped to deal with these stick patients.

- The demand for post-hospital care is expected to increase under DRGs--yet there is already a shortage of nursing home beds for Medicare patients and limited coverage for services under home and community health programs in many states.

Another study by the District of Columbia Hospital Association (DCHA) found that hospitals located in large, central cities are suffering severe financial consequences as a result of PPS. According to the study, "central city location and treatment of a large number of low income patients contribute to higher costs for city hospitals compared to their surburban counterparts. The cost per patient in the sample hospitals was $654 higher due to city location alone." The Secretary of DHHS is authorized by statute to make adjustments in the payment rate for those institutions that serve a disproportionate share of low income Medicare patients, but has neglected to do so.

ASIM believes that cutting hospital reimbursement will only exacerbate the problems identified by GAO and DCHA. Because of our early concern about the possible adverse effects of DRGs on patient care, the Society in March 1984 initiated its own survey of internists' experiences under PPS. Preliminary results of this survey, while drawn from a small sample size, corroborate many of GAO's findings. The Society plans to conduct a more scientific survey of the effects of DRGs on patient care and will be happy to share our findings with the Committee.

For the reasons identified above, ASIM strongly urges the Committee to reject the Administration's proposed fiscal year 1986 freeze on hospital reimbursement.

Increase Excise Taxes on Tobacco

The Society also strongly supports doubling the federal excise tax on tobacco products to 32 cents per pack, and earmarking those funds to the Medicare trust fund. At the very least, ASIM believes that Congress should amend the Tax Equity and Fiscal Responsibility Act to maintain the current level of taxation on tobacco products. Increasing excise taxes on tobacco would have the desirable effects of reducing the federal deficit; creating disincentives for people to smoke, particularly for price sensitive young people; requiring smokers to contribute more money to help compensate for the higher medical care costs they generate due to smoking-related illnesses; reducing interstate bootlegging; and improving the long term solvency of the Medicare program.

Part B Premiums and Deductibles

ASIM opposes any further increase in Medicare premiums and deductibles at this time.

Although the Society supports the concept of increased patient cost sharing as one mechanism for placing appropriate incentives into the health care system, the Society is concerned that these proposals will place an unacceptable financial burden on many Medicare patients, particularly low income beneficiaries. It is important to recognize that in 1981 Congress enacted several changes to increase patient cost sharing under the Medicare program, by increasing the Part B deductible to $75 and by providing for a more current basis for calculating the Part A deductible, thereby increasing beneficiary liability. Further increases in patient liability for Part B services could have the effects of forcing some lower income beneficiaries to discontinue supplemental medical insurance (Part B) coverage due to the higher premiums, and creating a financial barrier to receiving care as a result of the higher deductible. For these reasons, ASIM strongly opposes any increase in the Part B premium and deductible at this time in the absence of some mechanism to protect income beneficiaries.

Medicare Support for Graduate Medical Education

The Society has concerns over the administration's FY 1986 proposals to make changes in Medicare support for medical education without adequate study.

Although ASIM agrees that there is a need to consider whether or not post medical school education can best be supported by public and private financing programs other than Medicare, the Society strongly believes that support for medical education should not be withdrawn or reduced significantly until such a study is undertaken and alternative funding sources identified. Abrupt changes in Medicare support for post medical school education could have a major adverse effect on the hospitals now receiving Medicare funds, on health professionals currently in training programs, on individuals considering future careers in the health care professions, and ultimately, the general public, who could suffer if there is a sudden interruption in the availability of trained clinicians.

Nevertheless, ASIM recognizes that there may be more appropriate long-term funding sources for post medical school education, and thus supports continued study of this important concept.

Specifically, ASIM recommends the appointment of a commission or task force to explore alternative sources of funding for post medical school education. Such a commission, if mandated by Congress, should be established in such a way as to assure a broad base of representation, including physicians (both academic and practicing physicians), nurses and other health professionals, hospital administrators, representatives of Medicare beneficiaries, governmental officials, representatives of the private insurance industry, medical students and residents, and other appropriate individuals with expertise and interest in this subject. To assure that the commission develops recommendations that are not perceived to be self-serving, it is essential that its membership be as broad based as feasible and not be confined solely to those individuals and facilities (health professionals in training and hospitals) directly affected by the issue. Such individuals, however, certainly should be included in the commission's membership.

Therefore, ASIM recommends that Congress consider--as an alternative to making significant changes in Medicare support for post medical school education at this time--mandating the establishment of a commission (with representation as described above) that would be charged with making recommendations to DHHS and Congress on the feasibility of alternative sources of funding for post medical school education.

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The CHAIRMAN. Dr. Davis, home health care is normally well regarded by most of the members of the committee, and we fought hard for the waivers.

And yet, I have had a number of friends who are physicians in Oregon complain about the way that they are treated under the home health program. I wonder if you would like to elaborate on that?

Dr. DAVIS. Yes; we concur with you that this is a very fine method of delivering care, both from the patient's standpoint and from the economies involved.

It is better that that patient be at home if at all possible. We feel that home health care should be improved.

Unfortunately, reimbursement to physicians and their staffs who go out to provide this care currently is well underpaid. As you know, a home health agency on the average gets about $50 for a visit in a home health situation. A physician going out may get as little as $18. Except in rare cases, a physician cannot be reimbursed for services his or her staff provide at a patient's home.

We think this inequity should be changed so that the physician taking care of the patient, when the patient leaves the hospital, can continue his continuity of care by providing home health care, being reasonably reimbursed for what he does or what his staff does.

As a surgeon, if I discharge a patient from the hospital and, if I or member of my staff were to be allowed to take the stitches out, so as to save days postoperatively in the hospital, then I think reasonable reimbursement would encourage that.

Currently, there is a great inequity between the reimbursement to home health agencies and to physicians and their staffs.

The CHAIRMAN. A second question, Dr. Davis, which is unrelated to the first. The hospital industry argues that reimbursement rates for surgery performed in hospital outpatient departments should be higher than for ambulatory surgical centers because patients in hospitals are sicker and need better technology. Do you agree or not?

Dr. DAVIS. Are you referring to the hospital outpatient departments?

The CHAIRMAN. Yes.

Dr. DAVIS. I doubt very much if they are sicker in the outpatient department than many patients in ambulatory surgical centers.

I think that this should be more equitable. I think it should be brought in line. We have looked at the proposal of Senator Durenberger of capping outpatient surgery facility rates at the DRG inpatient rates, and in general, we concur with that, realizing that there are some DRG's which are inappropriate and do not accurately measure the resource cost that is involved with the procedure.

But we think that outpatient hospital services could be brought down more in line with the charges and the costs provided in ambulatory centers, particularly freestanding centers.

The CHAIRMAN. Next, the AMA has been very good about supporting preventive service demonstration projects, but we have a debate as to whether we should do it through schools of medicine or schools of public health.

How strongly does the AMA feel that preventive service demonstrations that in projects should take place in schools of medicine versus schools of public health?

Dr. DAVIS. Certainly, we think that this type of program should be done under the domain of medicine and medical schools in cooperation with schools of public health.

I really think that this could be worked out jointly between the two, but I think that the medical schools certainly should take the lead in providing this type of service.

The CHAIRMAN. Senator Long.

Senator LONG. No questions, Mr. Chairman.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Mr. Chairman, I want to thank the witnesses for their testimony. I am sorry I wasn't here for all of it.

The CHAIRMAN. Gentlemen, thank you very much.

Dr. ROEHRIG. Thank you.

The CHAIRMAN. Now, if we might move to a panel of Urbano Censoni, Barbara Matula, Michael Petit, and Robert Fulton.

Commissioner RUVIN. Mr. Chairman, you did not call my name. However, the record shows me as part of the panel.

The CHAIRMAN. Who are you?

Commissioner RUVIN. My name is Harvey Ruvin. I am here representing——

The CHAIRMAN. Pardon me. I did not realize you were on the same panel. I would be happy to have you join them.

I was going to have you testify by yourself, but please sit down with the rest of of the panel.

Commissioner RUVIN. Thank you, sir.

The Chairman. We will start with Mr. Censoni.

STATEMENT OF URBANO CENSONI, CHAIRMAN, GOVERNMENT AFFAIRS COMMITTEE, NATIONAL ASSOCIATION OF STATE MENTAL RETARDATION PROGRAM DIRECTORS, LANSING, MI

Mr. CENSONI. Thank you. I do want to thank the committee for this opportunity to testify this morning, and Senator for your pronouncing my name correctly.

The CHAIRMAN. Oh, thank you. You have about a 50–50 proposition.

Mr. CENSONI. I do apologize. I have hay fever and hay fever is in Washington, as well, I see.

My name is Urbano Censoni. I am the director of the Office of Community Residential Services for the Michigan Department of Mental Health.

Today I am appearing as the chairperson of the governmental affairs committee of the National Association of State Mental Retardation Program Directors. To my left is Mr. Robert Gettings. He is the executive director of the association.

The association represents the designated State officials providing services to over one-half million developmentally disabled people throughout the country.

As a result, we are deeply concerned with the evolution of Medicaid policy, especially as it impacts on the adequacy and the quality of services to the people we are entrusted to serve.

Today, of the total dollar amount paid by Medicaid on behalf of developmentally disabled people, over two-thirds goes for institutional care. That high disproportion of money for institutional care should not come as a surprise, given the historic and current bias in Medicaid for its institutional services.

In the next few minutes, I will attempt to highlight for the committee why changes in Federal Medicaid policy are urgently needed and what some of those changes are.

Despite the efforts by Congress to increase flexibility in the use of Medicaid funds on behalf of developmentally disabled folks, our efforts have been thwarted by Health and Human Services, who among other things through regulation and through formulas have inappropriately and unnecessarily limited the number of people that can be served on approved waivers, required community services to be substantially less costly than institutional care, and exclude payments for habilitative and work-training services.

When you add these barriers to the pressures created by the recent expansion of the Federal look-behind, States are increasing the number of ICFMR beds in their systems and are investing millions of dollars in their State institutions, at the expense of community programs.

These actions can only lead to less appropriate services and to higher Medicaid payments.

A recent case in Michigan, I think, exemplifies the policy dilemma that we are facing. Approximately 6 months ago, we were asked to serve Brian, a 2-year-old with health care impairments, who had been living in a special unit in a general hospital since birth.

Brian has a trach, was born without one leg, but it was clear that with the right kinds of services, Brian could grow up to be a productive member of society. The hospital unit in which he lived costs over $800 a day.

Given the Medicaid policy we have today, we had the following choices: place Brian in one of our State institutions for $160 a day; place him in a community group home, also Medicaid-funded at $120 a day; in a nursing home at $50 a day that we felt programmatically and ethically was untenable; in a foster home at $100 a day at 80-percent State cost; or to return Brian to his own home at about $100 a day, at total State cost.

Now, you might ask why was a system that was willing to spend $60 to $500 a day to keep Brian in an institution—why was it not willing to spend $50 a day to send him home?

The answer to that question really lies at the core of why we urgently need Medicaid reform. Why we have to eliminate the bias in the Medicaid system toward institutional care, and why we need the flexibility that we outline in our written testimony.

By the way, today Brian continues to live at home. He has learned how to walk on his artificial leg, has begun to talk. His medical problems have lessened, and his cost is now less than $60 a day, and we think it will go down from there.

Brian's story could be told 1,000 times throughout this country. We decided to invest additional State money to send him home, but without Medicaid reform, States—Michigan and others—will have no choice but to resort to higher costs and less appropriate forms of care in the future.

Senator CHAFEE. Mr. Chairman, could I interrupt here one moment?

The CHAIRMAN. Yes.

Senator CHAFEE. It seems to me that we are really getting to the very core of a major suggestion from Mr. Censoni. And as I understand it, the point you are making is about the Medicaid waiver. Is that it?

Mr. CENSONI. The waiver itself, sir, and then the whole issue of the way the Medicaid system is structured generally.

Senator CHAFEE. Yes; but what you are saying is that Medicaid will pay for certain expenditures; namely this youngster in a hospital. Is that correct?

Mr. CENSONI. Yes; it did pay.

Senator CHAFEE. It did pay that. But Medicaid will not pay for certain other placements of this youngster, and therefore, there is every incentive on behalf of the State to keep the youngster in the higher paying situation because that is cheaper to the State.

Is that your point?

Mr. CENSONI. Senator, it is cheaper and it is certain. Waivers are not certain, and that is part of the problem.

Senator CHAFEE. Was this in Michigan?

Mr. CENSONI. Yes.

Senator CHAFEE. All right. So, in Michigan the safe thing to do was to keep that youngster in the hospital at—did you say $800 a day?

Mr. CENSONI. He was in a special unit in a hospital for almost 2 years at $800 a day, sir; yes.

And then our option when he was referred to us was to send him to one of our State institutions at $160 a day, and that is a low cost that I am giving you, or in a community group home, also Medicaid-funded, at $120 a day.

And both of those forms of care clearly would have created dependency in Brian. He would still be in those kinds of situations, instead of being at home where he is.

Senator CHAFEE. But you got nothing from Medicaid if he went home?

Mr. CENSONI. No, sir.

The CHAIRMAN. We have been faced here with two issues. One is the problems we have with the waiver all the time about home care—whether you even get the waiver or not.

Mr. CENSONI. Right.

The CHAIRMAN. The second is that, assuming you got a waiver, what kind of services are you going to cover?

Senator CHAFEE. Yes; go right ahead.

Mr. CENSONI. I think that the question certainly dealt with the last part of my presentation.

We just want to make it very clear—and Senator, I think you said it earlier at the beginning of the hearing—that there is an issue here that flexibility is very important toward cost containment and providing good and adequate services.

The system as it currently is in place not only forces higher costs, but it forces people into systems that create dependency.

And how we can be in a situation where to take care of someone in an institution for the rest of their lives or the kinds of costs that we are talking about is somehow better or more cost effective than that person going home or going into a community residence or learning how to work and supporting them in that employment opportunity as adults is just beyond us.

We don't understand the logic in it.

The **Chairman**. Thank you, sir. Ms. Matula.

[The prepared written statement of Mr. Censoni follows:]

STATEMENT OF TESTIMONY

Deficit Reduction Amendments of 1985

Respectfully Submitted

to the

SENATE FINANCE COMMITTEE

The Honorable Robert Packwood, Chairman

by

Ben Censoni

Administrator, Program Development and Support Systems
Michigan Department of Mental Health

speaking on behalf of

National Association of State Mental Retardation
Program Directors, Inc.

September 13, 1985

I. INTRODUCTION

My name is Ben Censoni. I am the Administrator of Program Development and Support Systems within the Michigan Department of Mental Health. In that capacity, I am responsible for overseeing the Department's efforts to design and implement community-based services for mentally ill and developmentally disabled persons across the State. I also serve as Chairman of the Governmental Affairs Committee of the National Association of State Mental Retardation Program Directors (NASMRPD). Today, I appear before the Committee as a representative of the Association, although in my testimony I will draw extensively on my experiences in Michigan.

The membership of NASMRPD consists of the designated officials in the fifty states and territories who are directly responsible for the provision of residential and community services to a total of over half a million developmentally disabled children and adults. As a result, we have a vital stake in the evolution of federal Medicaid policy.

According to statistics complied by the University of Illinois at Chicago, federal Medicaid payments on behalf of an estimated 150,000 residents in intermediate care facilities for the mentally retarded (ICF/MR) totalled

$ 2.6 billion in FY 1984. Of this total, an estimated $ 1.9 billion was expended in large public and private institutions, while the remaining $ 700 million was obligated for community-based residential services.[1] In addition, the Health Care Financing Administration (HCFA) estimates that, as of June, 1984, 17,000 mentally retarded recipients were participating in programs financed through Medicaid home and community care waivers.[2]

II. THE CONSEQUENCES OF INACTION

Over the past ten years, we have witnessed a historic shift in the states' approach to serving developmentally disabled persons. Instead of incarcerating such individuals in large, remote, custodial institutions, the states have begun to develop a wide array of community-based day and residential programs for developmentally disabled clients. It is not unusual today to find persons who had been in institutions for twenty years or more living and working independently, or to see children who in past

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[1] Braddock, David, Richard Hemp and Ruth Howes, Public Expenditures for Mental Retardation and Developmental Disabilities in the United States: Analytical Summary. Monograph No. 6, Public Policy Monograph Series, Institute for the Study of Developmental Disabilities, University for the Study of Developmental Disabilities, University of Illinois at Chicago, March, 1985, p. A-7.

[2] Statement of Testimony by HCFA Administrator Carolyne K. Davis before the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives, June 25, 1985, p. 10.

years would have been placed in institutions enjoying life with their biological, adoptive or foster families.

This dramatic shift is reflected in both the decline in the number of persons served in large, state-operated institutions (from 166,247 in 1974 to 109,827 in 1984) and in the evolving patterns of state expenditures. For example, a recent analysis completed by the Institute for the Study of Developmental Disabilities at the University of Illinois (Chicago) revealed that, between FY 1977 and FY 1984, total state expenditures on behalf of developmentally disabled persons in community settings increased from $ 745 million to $ 3.1 billion, or by 316 percent. Of equal importance, this trend was evident in almost all states. In fact, 44 of the 51 jurisdictions studied experienced a real, after inflation growth in community outlays over the eight year period.[3]

Meanwhile, despite the rapid increase in federal ICF/MR expenditures (from $ 571 million to almost $ 1.9 billion), total federal-state support for institutional services plateaued over this same period, when measured in non-

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[3] Braddock, David, Richard Hemp, Ruth Howes, "Financing Community Services in the United States: An Analysis of Trends", Monograph No. 13, Public Policy Monograph Series, Institute for the Study of Developmental Disabilities, University of Illinois at Chicago, May, 1985.

inflated dollars.[4] Per capita costs of institutional care, however, have risen dramatically (from $ 44.64 in 1977 to $ 106.43 in 1984).[5] This reality, combined with the effects of current Medicaid policies, is placing many states in the position of having to choose between further expansion in community-based services or costly improvements in their existing institutional facilities.

Let me briefly illustrate this policy dilemma by referring to the situation facing Michigan. In FY 1977, our State spent $ 132 million on services to developmentally disabled persons, only $ 14.8 million (or approximately 11%) of which was devoted to community services; the remainder was used to support the operation of twelve state institutions housing over 6,000 mentally retarded persons.

In the intervening years we have closed four state institutions and reduced the number of people remaining in state facilities to 2,100, or to approximately one third

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[4] Braddock, David and Richard Hemp, "Intergovernmental Spending for Mental Retardation in the United States: An Analysis of Trends", Monograph No. 16, Public Policy Monograph Series, Institute for the Study of Developmental Disabilities, University of Illinois at Chicago, 1985.

[5] Braddock, David, Richard Hemp, Ruth Howes, Public Expenditures for Mental Retardation and Developmental Disabilities in the United States: Analytical Summary, Ibid.

the number in 1977. Meanwhile, our budget for community services has grown more than tenfold (to $ 126 million) and the number of clients served in various types of community programs has risen from 978 in 1977 to 5,567 today. Currently, Michigan has 3,300 ICF/MR certified beds -- 2,100 in state institutions and 1,200 in small, community-based homes. For purposes of the present discussion, it is important to point out that had Michigan elected to retain its 1977 institutional population in Medicaid-certified beds, the additional annualized cost to the federal government (in 1985 dollars) would have been roughly $ 27 million more than our current Medicaid ICF/MR receipts.

Despite Michigan's strong commitment and enviable track record in building a viable community service system, we find ourselves, at this point, handcuffed by perverse institutional incentives that are inherent in Medicaid policy. Let me explain.

Even though the cost of community residential services runs an average of 40 percent less than institutional costs, every time we move a client out of one of our state institutions into a community residence, or divert an individual from placement in an institution, the cost in state dollars to Michigan is approximately $ 4,500 annually. Why? Because we receive 56 percent Medicaid reimbursement on behalf of institutional residents, compared to minimal federal assistance on behalf of clients in our non-ICF/MR community residences.

Over the past two-and-one-half years, the disincentive effect of Medicaid's institutional bias has been partially offset by the fact that the State has had a Medicaid "freedom of choice" waiver covering community-based day services for mentally ill and developmentally disabled recipients. However, HCFA recently informed the State that it would not renew this waiver program, because in their estimation it was not cost-effective. The program, therefore, will terminate later this year.

To offset the revenue lost when the waiver renewal was disapproved, recently Michigan began certifying an addition 900 community ICF/MR beds -- despite our reservations about the long term efficacy of this approach. Furthermore, most of our new residential development over the next two years will be concentrated in community ICF/MR facilities; as a result, we expect to have 1,500 more ICF/MR beds on line by the close of FY 1987, plus about 300 beds per year will be added to this total in each succeeding fiscal year. The added ICF/MR cost to the federal government by the close of FY 1987 will be approximately $ 35.6 million, or considerably more than the cost of waiver services in the current fiscal year.

If I could leave one message with the Committee, it would be this: failure to grant the states increased flexibility in managing Medicaid long term care funds will result in increased federal costs, not cost containment. Unfortunately, it also will mean that we will be able to offer services to fewer eligible recipients in settings which foster continued dependency, rather than integration into the mainstream of society.

A rational federal long term care policy should attempt to encourage the states to:

- assist families to maintain their developmentally disabled children at home. Although Michigan and a number of other states have begun to provide in-home services and subsidies to make it possible for parents to maintain their severely disabled children at home, current Medicaid deeming policies impede the achievement of this goal by counting parental income and resources when the child is living at home, but disregarding them once a child is placed in an out-of-home care setting.

- choose the type of living arrangement for disabled adults that will maximize their opportunity for social integration and independence. Michigan has demonstrated that it is not only efficacious but cost-effective to develop specialized living situations for severely disabled adults. For example, if the State were to receive federal Medicaid matching for non-ICF/MR settings to serve the previously discussed 1,500 clients we plan to place in such certified facilities, we estimate that the average per capita cost per bed could be reduced by $ 42.00 per day. This would represent an annual saving of $ 12.9 million to the federal government. Futhermore, we are convinced that such clients would receive better services.

- maximize the productive capacities of developmentally disabled adults, by offering them vocational training and supported employment services. To maintain clients in a perpetually dependent state makes no sense. We have the technology to make thousands of "unemployable" developmentally disabled adults, productive workers, if we are willing to provide the appropriate work environments and social supports for such persons. Once more, by doing so, we can dramatically reduce the long range cost of serving such clients.

Current Medicaid policy, by locking the states into an "all-or-nothing" set of funding options, discourages the development of more appropriate and cost-efficient funding alternatives in the community. The home and community care waiver program was intended to serve as a first step toward addressing this basic program flaw. Unfortunately, as will be indicated in the succeeding section of my testimony, the current Administration has used its administrative authority to undermine the effectiveness of the program. To further complicate the situation, the present round of ICF/MR "look behind" surveys is forcing states to invest millions of dollars to correct deficiencies in large public and private facilities. While these expenditures may result in improved programming for a few current institutional residents, our Association is concerned that the resulting outlays also will effectively limit further expansion in community-based day and residential programs in many states.

III. PROBLEMS ASSOCIATED WITH THE OPERATION OF THE MEDICAID HOME AND COMMUNITY CARE WAIVER PROGRAM

When Congress empowered the Secretary of Health and Human Services to approve Medicaid home and community care waivers in 1981, by adding Section 1915(c) to the Social Security Act, the intent was to grant the states greater latitude in designing appropriate, cost-effective alternatives to providing chronically disabled, Title XIX recipients with care in nursing homes and other institutional settings. Prior to the enactment of these amendments (Section 2176 of P.L. 97-35), most states offered little or no coverage of non-institutional long term care services under their Medicaid plans.

Initially, it appeared that the waiver authority would provide states with a powerful new tool for neutralizing the bias toward institutional forms of care which has characterized Medicaid long term care policy since the program was originally authorized in 1965. I regret to report, however, that administrative policies instituted by HCFA (with the encouragement of OMB) over the past two years threaten to undermine the utility of this once promising program.

Let me briefly outline some of the problems caused by the regulatory and administrative restrictions instituted by HCFA. Later in my testimony, I will suggest several specific statutory amendments which, we believe, would correct these problems. At the outset, however, I want to emphasize that the steps we are proposing represent, in our view, a means of fulfilling the original intent of Congress, rather than an expansion of existing program benefits. We are fully cognizance of the difficult task the Committee faces in attempting to balance the pressing human needs represented by the wide panoply of programs under its jurisdiction with the budget restrictions set forth in the First Concurrent Budget Resolution for FY 1986 (S. Con. Res. 32).

A. Limitations on the Number of Eligible Recipients. Under current waiver regulations, the states are required to furnish HCFA with extensive documentation regarding the number of present and projected Medicaid-certified beds in SNF, ICF and/or ICF/MR facilities, with and without the proposed waiver program. In instances where the proposed number of waiver recipients would exceed the present capacity of Title XIX-certified beds, a state is required to include in its waiver request convincing evidence that the additional institutional beds needed to serve the intended waiver population, in fact, would be available in the absence of the requested waiver program. If the state is unable to establish, to HCFA's satisfaction, that the requisite number of institutional beds would be available without the waiver, the state's Section 1915(c) request generally will not be approved.

The effect of this administrative policy is that: (a) states are precluded from reinvesting any savings that might be associated with furnishing recipients with community-based vs. institutional services into expanded diversionary programs, aimed at reducing current and future demand for institutionalization; (b) states face strong fiscal incentives to serve only those waiver-eligible recipients who require the most extensive and costly array of community-based services; (c) states with relatively low per capita rates of institutionalization and/or unusually high demand (current and projected) for long term care services, are at a clear disadvantage, since such interstate differences are not accounted for in HCFA's present methodology of calculating the projected growth in SNF, ICF or ICF/MR beds; and (d) the fiscal consequences of a proposed waiver program are considered only in terms of their short range fiscal impact, rather than within the context of longer term demand for services.

Let us illustrate the effects of HCFA's current policies by briefly summarizing the disposition of

Florida's waiver renewal request. Under the terms of the State's original waiver request, approved by HCFA in 1982, the Florida Department of Health and Rehabilitative Services was permitted to serve an average monthly caseload of 6,665 developmentally disabled clients during the third year of the program. In its renewal requests, submitted to HCFA in March, 1985, Florida officials requested authority to cover an average monthly caseload of 7,800 DD clients in the fourth year of its waiver program. HCFA's initial response was that, according to its calculations, the State could cover only 43(!) recipients, a figure representing the number of vacant beds in ICF/MR-certified facilities, statewide.

Although State officials pointed out that Florida had over 9,000 severely developmentally disabled clients who lacked appropriate services, had significantly scaled down its institutional population over the preceding fifteen years (from 6,107 in 1970 to 2,200 in 1985) and, consequently, had one of the lowest per capita rates of institutionalization in the nation, HCFA refused to approve the State renewal request. Finally, after months of negotiations and hundreds of staff hours spent on preparing justifications, HCFA agreed to permit the State to offer waiver services to a maximum of 2,300 eligible recipients -- or roughly one-third the number DRS had previously been serving.

State officials subsequently informed HCFA that it intended to reorient its waiver program to concentrate on high cost clients. As a result, total federal waiver outlays for year four will be approximately the same as in year three, although 65 percent fewer recipients will receive services.

B. Limitations on Comparative Costs. Although the existing statute clearly specifies that, in order to qualify for a Section 1915(c) waiver, a state must prove that average per capita expenditures for waiver services will "not exceed" average per capita expenditures for institutional care, HCFA officials have told a number of states that if the average per capita cost of waiver services exceeds 75 (or sometimes 80) percent of institutional costs, the state's proposed waiver program would not be approved. The purported rationale for this interpretation is that Congress, in enacting the waiver authority, intended to achieve short term savings in Medicaid outlays. Yet this interpretation clearly violates the literal meaning of both the statute and HHS's implementing regulations.

C. Limitations on Covered Services. HCFA has taken the position that prevocational services, vocational training and educational activities do not constitute habilitation services reimbursable under a Medicaid home and community care waiver (see page 10020, Federal Register, Vol. 50, No. 49, March 13, 1985). Although HCFA has never indicated how it expects the states to distinguish between habilitation, education and vocational (or prevocational) training for purposes of Medicaid reimbursement, the agency has disapproved the waiver requests of several states (and required modifications in others) on the grounds that they were planning to furnish prevocational or vocational training to developmentally disabled waiver recipients.

Current HCFA policy has the effect of encouraging states to retain waiver-eligible MR/DD recipients in a perpetually dependent status, since the cost of services aimed at assisting such clients to acquire greater economic self-sufficiency are treated as non-allowable expenditures. Such a policy makes no sense in either humanistic or fiscal terms, since we now have an extensive body of evidence that demonstrates that even severely retarded, multi-handicapped persons can be trained to be productive employees, if they are offered the social supports (e.g., sheltered living, transportation, case management, on-the-job training and supervision, etc.) available through the waiver program.

D. *Limitations on Federal Reimbursements*. Under the provisions of HHS's final waiver regulations, states will not be reimbursed for any waiver expenditures in excess of the amount estimated in their original waiver request (see Section 441.310(a)(2), *Federal Register*, Vol. No. 49, March 13, 1985, p. 10028). In other words, the basic federal-state cost sharing principles that undergird Medicaid does not apply to the Section 1915(c) waiver program. Instead, the states are being asked to assume the entire risk of cost overruns, even though a state may have little or no control over the precipitating causes of such overruns.

Had Congress intended to limit, or "cap", federal financial participation in waiver expenditures, it would have included such a provision in the original authorizing legislation or subsequent amendments. But, it did not elect to do so. Therefore, in the absence of any explicit (or even implied) Congressional authority, the Secretary clearly lacks the administrative power to impose a regulatory cap on federal cost sharing.

E. Cost Comparisons for Non-Elderly, Physically Handicapped Recipients. Currently, HCFA requires a state to compare the average per capita cost of the proposed waiver services with the average per capita state-wide cost of SNF, ICF and/or ICF/MR services (depending on the type of nursing care facility in which such recipients otherwise would receive services.) While this type of comparison may be reasonable in the case of elderly and mentally retarded waiver recipients, it effectively precludes the initiation of waiver services for many non-retarded developmentally disabled persons who are either institutionalized or at risk of institutionalization.

Since a state must compare projected home and community care costs with the statewide average cost of all ICF facilities, they usually find that the lower payment standard for geriatric nursing homes in the state makes it impossible to prove that home and community care services represent a cost effective alternative for such recipients. As a result, few states have submitted waiver requests on behalf of this population of potential recipients.

F. Extension of the Waiver Renewal Period. Under current law, the Secretary is authorized to approve a Section 1915(c) waiver request for an initial term of three years. Once approved, a waiver program may be renewed for additional three-year periods, provided the Secretary finds that the requesting state has fulfilled its statutory assurances during the preceding three-year period.

Because a state's waiver renewal cycle may not coincide with its budget and planning cycles, the need to obtain Secretarial approval to continue the program once every three years adds an element of instability to the program -- especially given the difficulty states have encountered in their efforts to obtain a prompt response from HCFA to their waiver renewal requests. This problem could be partially ameliorated by extending the length of the waiver renewal period.

IV. RECOMMENDATIONS FOR COMMITTEE ACTION

The Association respectfully urges the Committee to adopt three parallel sets of amendments to Title XIX of the Act, in order to address the problems outlined above. The initial series of proposed statutory modifications are intended to prevent administrative excesses in the operation of the existing Medicaid home and community care waiver program and assure that it is implemented in accordance with the original intent of Congress. The second proposal outlines a suggested approach to integrating coverage of home and community care into a state's ongoing Medicaid program, without comparative increases in federal and state outlays. Finally, we offer several related amendments to the Act as it impacts on federal ICF/MR policies.

A. Clarifying Amendments to the Section 1915(c) Waiver Authority. Among the specific modifications which should be made in the statutory authority for Medicaid home and community care waivers are:

1. Amend Section 1915(c)(2)(D) by adding a list of the statistical and demographic factors which the Secretary must take into account in reviewing state waiver requests. These factors would

include: (a) statistically valid demographic studies which offer reasonable grounds for concluding that the number of individuals who would require care in a SNF, ICF or ICF/MR facility is likely to increase, by a specified amount, if the requested program is disapproved or terminated; (b) the impact disapproval or termination of the subject waiver program would have on past, successful efforts by the state to restrict the number of new admissions and readmissions to Medicaid-certified long term care institutions; and (c) statistical evidence that the relative proportion of recipients receiving SNF, ICF and/or ICF/MR services under a state's Medicaid plan, per 100,000 in the general population, is below the national median for all states.

The proposed language would clarify the original intent of Congress, by requiring HCFA officials to take into account interstate differences in current and future demand for long term care services--instead of tying waiver eligibility to a state's projected institutional bed capacity. At the same time, states would still be obligated to demonstrate, in their waiver requests, that projected long term care expenditures would be no greater with vs. without the proposed waiver program.

2. Add a new subsection (e) to Section 1915 of the Act, in order to explicitly limit the Secretary's authority to restrict the number of recipients eligible to participate in a waiver program, provided the requesting state is able to document the cost-effectiveness of its proposed program. Again, the inclusion of such language would assure that the program was carried out in accordance with the original intent of Congress. A state still would have to prove that its proposed waiver program would be cost effective; but, it no longer would be obligated to also demonstrate that there would be no substantial increase in the total number of recipients of LTC services.

3. Amend Section 1915(c)(2)(D)d the Act by adding "100 percent of" before the words "does not exceed". The net effect of the proposed amendment would be to underscore the original intent of

Congress -- i.e., that waiver services should be cost neutral, not necessarily achieving net dollar savings. It is worth noting that identical language is included in the budget reconciliation bill (H.R. 3101) reported out by the House Energy and Commerce Committee on August 1.

4. Add a statutory definition of the term "habilitation services" by inserting a new subsection (d) to Section 1915 of the Act. The definition should read as follows:

> (d) the term "habilitation services as used in subsection (c)(4)(B) shall mean services designed to assist eligible developmentally disabled recipients to acquire, retain and improve the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings, including prevocational, educational and supported employment services. Provided thatsuch payments shall not be available to otherwise eligible recipients for --

(1) Special education and related services as defined in Section 602 (16) and (17) of the Education of the Handicapped Act, as amended, which otherwise would be available to such school-aged recipients through the recipients' local educational agency.

(2) Vocational rehabilitation services which otherwise would be available to such recipients through programs funded under Section 110 of the Rehabilitation Act of 1973, as amended.

The purpose of this amendment would be twofold: (a) to establish clear statutory parameters of Title XIX reimbursable habilitation services under an approved Section 1915(c) waiver program, thus reducing the possibility of later disputes over allowable claims; and (b) to permit prevocational and supported employment services for eligible recipients with developmental disabilities to be treated as reimbursable waiver costs, provided these services are not otherwise available to such recipients through the federal-state vocational rehabilitation program.

Similar language is contained in the budget reconciliation bill reported out by the House Energy and Commerce Committee (Section 202(a), H.R. 3101-Waxman), except that the House definition applies only to previously institutionalized recipients of waiver services. We strongly recommend that the Committee make the proposed definition applicable to all developmentally disabled recipients of waiver-financed habilitation services -- not just those who previously resided in Medicaid-certified institutions. To do otherwise would result in the application of unique definitions of the term to two otherwise indistinguishable groups of waiver recipients. Such a result would add to the complexity of administering the program, without achieving any reduction in service costs.

5. Add a new paragraph to Section 1915(c) of the Act which prohibits the Secretary from holding states to their original estimates of home and community care costs, as a condition of waiver approval. The addition of this proposed language would offer the states assurances that federal financial participation in waiver expenditures would be treated the same as any other Medicaid cost allowable under their state plans. Given such assurances, states are more likely to use the waiver authority on behalf of aged and disabled Medicaid recipients with long term care needs.

6. Add a new subparagraph to Section 1915(c) of the Act which allows the states to compare the average per capita cost of wavier services on behalf of non-elderly, physically handicapped recipients with the average per capita costs of specified nursing homes that specialized in caring for similar groups of recipients, rather than with the average per capita cost of all ICF facilities in the state. The proposed language would permit states to present more accurate comparisons of institutional vs. community care costs for non-elderly, physically handicapped recipients of

Medicaid services. Hopefully, the net effect will be that states will find it more feasible to deliver waiver services to selected recipients who fall into this diagnostic category. Again, the Committee should note that an identical provision is contained in the House version of the budget reconciliation bill (Section 202(d), H.R. 3101).

7. Amend Section 1915(c)(3) of the Act to extend the waiver renewal period from three to five years. The length of the initial waiver period would be unchanged (i.e., three years).

   Extension of the waiver renewal period should add to the stability of the program, thus allowing state officials, legislative bodies and provider agencies to focus their attention on improved day-to-day management of the program. It also would reduce the time federal officials must devote to reviewing waiver renewal requests.

B . Authorizing Coverage of Home and Community Care Services Under a Medicaid Plan Amendment. While, as indicated above, it would be possible to correct some of the most pressing problems surrounding the operation of the Section 1915(c) waiver program through a series of corrective and clarifying amendments, NASMRPD believes that ultimately the only effective means of permanent eliminating the institutional bias of Medicaid policy is to permit states to cover home and community care services as an integral part of their ongoing Medicaid programs. Therefore, we will outline our suggestions regarding the contents of legislation to achieve this purpose.

1. Basic Approach. The proposed legislation should add a new state plan option called "home and community care services", under Section 1905(a) of the Social Security Act. States should be permitted to cover a wide range of community-based services for eligible elderly and disabled persons under this proposed new plan option.

   Coverage of home and community care services as a Medicaid plan option should be designed to supplement rather than replace the home and community waiver authority. States should be permitted to cover HCBC services under their regular Medicaid plans for any one or combination of the following types of recipients who otherwise would require care in a Medicaid-certified institution (i.e., a SNF, ICF of ICF/MR-certified facility): (a) elderly and disabled persons; (b) mentally retarded and other developmentally disabled persons; (c) mentally ill persons; and (d) physically disabled, non-elderly recipients. By electing to cover one or more of these subpopulations of eligible recipients, a state should be under no obligation to extend coverage to other subpopulation of LTC recipients. Indeed, a state should be permitted to simultaneously elect to offer such services to one LTC subpopulation under its state plan and another under a Section 1915(c) waiver program.

In order to be permitted to cover HCBC services to any specified subpopulation of LTC recipients under a state plan amendment, a state should be required to offer a defined range of services, including, at a minimum, case management, respite care, adult protective services, transportation, homemaker/home health aides, personal care or residential habilitation services, and adult day or day habilitation services. These and other additional services the state might elect to cover should be available to eligible recipients in all geographic areas of the state on a comparable basis (i.e., the provisions of Section 1902(a)(1) and (10) of the Act could not be waived).

Two reasons can be offered for allowing states the option of covering identified subpopulations of LTC recipients under its state Medicaid plan. First, experience with the Section 2176 waiver authority indicates that states, given the choice, generally elect to organize distinctive programs for elderly/disabled as compared to developmentally disabled recipients; among the observable differences between DD-related waiver programs and similar programs for elderly/disabled persons are the range and types of services provided, geographic coverage, eligibility standards and methods of state/local administration. And, second, a state that is prepared to develop home and community care options on behalf of one subpopulation of long term care recipients (e.g., the developmentally disabled) may not be in a position to take similar action on behalf of another subpopulation (e.g., the elderly); decoupling services for the two subpopulations, therefore, would allow the states somewhat greater flexibility than an "all or nothing" choice.

2. Definitions. The term "home and community care services" would be defined under the proposed legislation, to include: case management services, homemaker/home health aide services; adult protective services; personal care services; adult day health services; habilitation services, respite care and such other services as a state may request and the Secretary approve. Payments for room and board, however, would be explicitly excluded from the definition.

The term "habilitation services", in turn, would be defined to encompass a wide range of health, health-related and habilitative services for Medicaid-eligible developmentally disabled recipients, other than: (a) educational services otherwise available to such school-age recipients through each child's local educational agency; and (b) vocational training services, other than services otherwise available to such recipients through the federal-state vocational rehabilitation program (see discussion under IV-A-4 above).

3. Conditions of Coverage. In order to qualify any of the four subpopulation of LTC recipients for Title XIX reimbursement of home and community care services under its Medicaid plan, a state would have to furnish the Secretary with written assurances that it would: (a) maintain at least its current level of fiscal effort in supporting similar services for eligible (and potentially eligible) recipients through available state and local funding sources; (b) restrict such services to recipients who, in the absence of such assistance, would require care in a Medicaid-certified long term care institution, the average per capita cost of which was estimated to

be equal to or greater than the cost of proposed home and community care alternatives; (c) institute necessary safeguards to protect the health, welfare and human rights of recipients participating in services provided under this plan option; and (d) furnish the Secretary with such information and data as may be required to assure efficient and effective administration of the program.

In addition, the state would be obligated to submit a comprehensive plan which includes provisions for: (a) instituting a comprehensive screening and assessment program to identify the service needs of eligible recipients currently placed in SNF, ICF and/or ICF/MR facilities, as well as otherwise eligible persons with similar needs who were either unserved or underserved and could benefit from home and community care services; (b) establishing appropriate level of care criteria, policies and procedures to be used in determining eligibility for all long term care services offered to Medicaid recipients within the eligible LTC subpopulation(s); (c) establishing a pre-admission screening program aimed at assuring the potentially eligible recipients, in need of long term care services, are placed in residential and day program settings that, consistent with their individual service needs, prevent premature regression or deterioration and, where appropriate, maximize their opportunity for independence and acquisition of adaptive skills; (d) systematically reducing the number of recipients with disabilities placed in SNF, ICF and ICF/MR facilities over a multi-year period; (e) developing, over a multi-year period, the home and community care services required to meet the needs of eligible recipients currently placed in institutional settings, as well as otherwise eligible persons who are unserved or underserved and could benefit from long term care services provided under the state plan; and (f) coordinating the activities of responsible state and local agencies to achieve the objectives of this plan.

4. Limitations on the Secretary's Authority. In order to avoid the imposition of unwarranted

administrative restrictions on a state's flexibility to plan and implement HCBC services on behalf of eligible recipients (similar to those experienced with the Section 2176 waiver program), the proposed legislation would restrict the Secretary's authority to disapprove a state's plan to cover home and community care services for selected subpopulations of recipients designated by the state unless: (a) the state fails to provide the Secretary with the required statutory assurances; (b) there is clear and convincing evidence that the state had, or planned to, furnish Title XIX-reimbursable HCBC services to recipients who would not otherwise require care in a Medicaid-certified institution, or where the average per capita cost of HCBC services exceeded or would likely exceed the average per capita cost of institutional care on behalf of the subject recipients; and (c) the state fails to submit a long range service plan which conforms to the specifications of the statute, as outlined in item 3 above.

The legislation also would make clear that nothing in the statute authorizes the Secretary to: (a) impose numerical restrictions on the number of HCBC recipients a state may serve under its state plan, provided the subject state is able to document the cost-effectiveness of the proposed services; (b) limit the manner in which a state chooses to compare relative costs for community based vs. institutional care recipients, so long as the state is able to document the overall cost-effectiveness of the proposed program; and (c) delay administrative action on state requests to cover HCBC services under its Medicaid plan beyond 90 days from the date of receipt of such a request.

C. Other Proposed Amendments. In addition to the statutory modifications suggested above, NASMRPD recommends that the Committee consider several specific modifications in federal ICF/MR policies, aimed at achieving the same basic objective -- i.e., assuring that developmentally disabled recipients receive services in the most appropriate residential settings.

1. Deinstitutionalization of the Developmentally Disabled. Last year, HCFA launched an intensive series of validation surveys (or look-behind

reviews) of ICF/MR-certified facilities across the country. These reviews are uncovering a variety of deficiencies in the operation of such facilities that will require correction. In certain instances, it seems clear that the funds necessary to correct such deficiencies would be better invested if an intensive effort were made to develop appropriate community alternatives for at least a portion of the facility's residents -- thus precluding the need to add scores of new staff or undertake extensive renovations in antiquated institutional buildings. HCFA's existing practices, however, effectively preclude depopulation strategies as part of a facility's correction plan, since detailed corrections plans must be submitted within 90 days of receipt of the notification of deficiencies and all corrective actions must be completed within 180 days thereafter.

To address this problem, we recommend that the Committee amend Section 1910(c)(20) of the Act to: permit a facility certified as an ICF/MR which has serious (but not life threatening) deficiencies, to pursue, as one possible strategy for correcting such deficiencies, a multi-year plan for reducing the net number of facility residents. Before a facility could initiate such a deinstitutionalization strategy, however, it should be required to submit, as part of its plan of correction, a detailed description containing the number and types of residents to be placed, the timelines to be observed and the methods to be used in effectuating such community placements. Should a facility fail to achieve any of its interim (6 months) placement goals, the state would suffer a proportional reduction in federal financial participation. The requesting state also should have to demonstrate that the projected five year cost of including depopulation as part of the proposed facility correction plan would be no more expensive than had the facility's population remained unchanged and funds been allocated to make the necessary improvement in the facility.

By allowing a state to reduce a substandard facility's population, as part of an overall strategy for responding to identified deficiencies, it should be possible to avoid costly investments in facilities that may not be in keeping with the longer range plans of the state or the best interests of the facility's residents. There would be no additional federal costs associated with such permissive language, since the state would be required to demonstrate that depopulation constituted a cost effective alternative to the staff enhancements and facility improvements that otherwise would be mandated under the correction plan.

2. Adoption of the 1985 Life Safety Code. Another issue which has emerged from the current round of HCFA "look behind" surveys is the effects of enforcing the national Life Safety Code in small community-based ICF/MR facilities. Under existing federal ICF/MR standards, the states are permitted to apply the rooming and boarding house chapter of the Life Safety Code (rather than the institutional chapter of the Code) when a facility has 15 or fewer beds and is caring for clients who are ambulatory and capable of self preservation in a fire emergency.

Applying a newly promulgated procedure for conducting unannounced fire drills, HCFA survey teams have determined that a number of ICF/MR community residences have clients who fail to respond appropriately to a fire alarm. Therefore, they have threatened immediate decertification of such facilities.

Meanwhile last year the National Fire Protection Association adopted a revised version of the Life Safety Code. This latest edition of the Code includes a new set of standards specifically crafted for board and care home occupancies. It also includes a special methodology for evaluating the relative fire safety of such facilities, by weighing the physical features of the facility, the capabilities of the residents and the availability of the staff.

If this new version of the Code were used, knowledgable experts believe that many of the community ICF/MR residences that are threatened with decertification would be found to meet the

Code. Although HHS is in the process of considering a rule change to adopt the new Code, it could be many months before the rule is officially promulgated. In the meantime, a significant number of facilities could be decertified and their residents returned to larger institutional settings.

To correct this situation, NASMRPD recommends that the Committee amend the Social Security Act to mandate the adoption of the 1985 edition of the Life Safety Code, for purposes of determining the fire safety of Medicaid and Medicare certified facilities, effective upon enactment of the bill.

Prompt adoption of the 1985 Code will permit many small community ICF/MR residences to avoid the cost of installing expensive sprinkler systems and making other facility modifications, when adjustments in staff coverage patterns and other relatively modest changes in the program may permit them to meet the new Fire Safety Evaluation System. Consequently, wasteful, disruptive requirements -- that will soon be superceded in any event -- can be avoided.

3. Definition of Active Treatment. Prior to April of this year the Office of the HHS Inspector General recommended that federal payments be disallowed for services to ICF/MR residents in seventeen states, on the grounds that the affected states had claimed reimbursement for nonallowable educational and vocational training services. These audit exceptions covered programs and activities that traditionally had been considered part of the active treatment services an ICF/MR facility is responsible for furnishing to its residents.

At this point, Senator Lowell Weicker (R-CT) intervened and, after a series of negotiations, HHS Inspector General Richard Kusserow agreed to halt further audits pending the issuance of a clear Departmental policy on how to distinguish between reimbursable habilitation costs and non-reimbursable education and vocational training expenses. Since that time, HCFA officials have been working on a set of guidelines to differentiate between the types of service costs allowable and non-allowable under Medicaid. However, given the importance of this definition to the operation of the program, it seems more appropriate to define in law the parameters of services reimbursable under Medicaid.

The Association recommends that a statutory definition of the term "active treatment" be added to Section 1905(d) of the Act. The term should be defined to include a wide range of developmentally-oriented habilitation services designed to assist eligible recipients in acquiring and retaining the self help, socialization and adaptive skills necessary to achieve and maintain their optimal level of functioning. The following activities would be explicitly excluded from the statutory definition of active treatment services: (a) special education and related services that are available to school-age recipients through their local educational agencies; and (b) vocational rehabilitation services available to such recipients through the federal-state vocational rehabilitation program. In other words, the definition would closely parallel the proposed definition of "habilitation services" under the waiver (see Section program IV-A-4 above).

Adding a statutory definition of active treatment would eliminate the considerable friction which has developed between federal and state officials over the past few years. It also would place stronger emphasis on achieving client-centered habilitation goals, without any added costs to the Medicaid program.

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On behalf of the Association, I want to thank the Committee for offering me this opportunity to express the organization's views on this important subject. If we can be of further assistance as the Committee pursues its work, I hope you will call on us.

STATEMENT OF BARBARA D. MATULA, DIRECTOR, NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE, RALEIGH, NC; ON BEHALF OF THE STATE MEDICAID DIRECTORS ASSOCIATION OF THE AMERICAN PUBLIC WELFARE ASSOCIATION

Ms. MATULA. Good morning. I am Barbara Matula. I am chairman of the State Medicaid Directors Association, as well as director of the North Carolina Division of Medical Assistance.

I had not heard my colleagues' testimony prior to sitting down here. I had not read it, but I agree with it 100 percent and would like to incorporate it as part of my testimony as well.

State Medicaid agencies come to you with their concerns about how the waiver is handled, about the limitations within the waiver, and urge you fervently to consider the waiver as a temporary measure, not an end in itself, and to try and seek some permanent solution to this very, very great problem.

Since 1981, we have been experimenting under the waivers, or trying to, with how to provide services outside an institution in a cost-effective and efficient manner.

We have done this in spite of and not because of HCFA's assistance.

We are told that as States we are villainous in our desire here to explode the budget. This is not true. The States support the very serious concerns of budget neutrality in offering this service.

We are well aware after 20 years of experience of how difficult it is to estimate need and the explosive nature of offering a new service without limits. But we feel that the concern with the deficit has become almost myopic in this area because we are willing to spend $800 a day in a hospital without limit and have somehow artificially constrained our ability to provide lower cost alternatives.

Of the major problems that we see with the waiver one is that the formula used is perverse. It has incentives for States to build more nursing homes, more institutions, rather than to close them down, because the number of people we can serve is tied to the number of beds we have.

While this makes for a very convenient measure for the Federal Government, it is a silly measure. And a State that has been very effective in holding down nursing home bed growth is now penalized in not being able to provide the kind of care in the home to the number of people it needs to serve.

The States, if there are any, that are overbedded now can serve many more people in the home. So, as you can see, the incentive is perverse.

The second problem we have is that we have an artificial limit on what we can spend in the home. We have no limit on what we can spend in an institution basically, but we are told that the average per capita cost of home care cannot exceed 75 percent of institutional care costs.

We are further limited by total expenditures. And in an effort, I suppose, to make Medicaid directors even more agile than they are now, we are penalized if we exceed our estimates of expenditures, even if those actual expenditures are lower than institutional expenditures.

This is a highly unusual penalty, and one which I am not sure any of us can live with.

If we exceed our expenditures, not only will we not get Federal match on those expenditures, but we could lose our waiver. And that brings me to the third area.

And that is the administrative handling of the waivers. In getting one or in renewing one, it is almost a test of wills and endurance.

There is a 90-day clock that is supposed to be ticking. In fact it it is an interminable clock. It is an eternal clock. On the 89th day, a request for information can trigger a new 90-day period, and there are no limits to the number of times that this sort of ploy can take place.

Solutions. There are many. The States polled by Oregon, in fact, overwhelmingly support State option rather than State waiver, just to avoid the very problems we have discussed, but we recognize that the problem there is in how to control the costs.

We think it can be done, and we would like you not to dismiss that possibility too lightly. We believe we can hold costs down.

We know that we have to have a better measure of need than the number of nursing home beds. Perhaps something as simple as estimating the elderly population growth and population.

But we do urge you to help us with ameliorating the situation, or we feel States will be discouraged and will simply drop out of the waivers rather than continue to arm-wrestle over something that makes so much sense.

Thank you.

The CHAIRMAN. Thank you. Mr. Petit.

[The prepared written statement of Ms. Matula follows:]

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TESTIMONY OF

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OF THE

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AND

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FOR THE

COMMITTEE ON FINANCE

HEARING ON DEFICIT REDUCTION OPTIONS

September 13, 1985

Mr. Chairman, members of the committee, good morning. I am Barbara D. Matula, director of medical assistance for the of North Carolina. I am also currently serving as chairperson of the State Medicaid Directors' Association of the American Public Welfare Association. I come before you today to offer the states' thoughts and comments regarding the home and community-based services waiver program--also known as the 2176 waiver program.

The states have learned a great deal since the passage of the Omnibus Bduget Reconciliation Act of 1981, which enabled us to pursue home and community-based services as an alternative to institutional care. As you know, the program was established as part of an overall package of changes aimed at providing states more flexibility, in the face of a significant reduction in federal financial participation. As of July 15 of this year, 47 states had received approval for 78 waivers to provide home and community-based services to the aged, mentally retarded, and mentally ill. Twelve states have applied for renewals or replacement waivers, and of these, 7 have been approved. While most of the existing waivers began by covering only a relatively small number of individuals, it has been the states' intent to expand, if necessary, as more knowledge has been acquired on how to implement and operate home and community-based service systems. The great merit of the waiver program as established in law has been that it provides the states with an avenue to start moving away from the bias to institutionalize people that existed in Medicaid prior to OBRA. While few of us expected any wholesale change in the structure of the program, we did believe that the waivers would be a first and very important step in providing states with the ability to bring about more of a balance between institutional care and the underdeveloped community care system.

Unfortunately, the waiver program has not lived up to our expectations. The administration's implementation of the program has deviated from congressional intent and thwarted states' plans to develop home and community-based care. The requirements that HHS has developed are more likely to deter, rather than encourage states to seek waivers. Although intended to ensure that the program does not cost additional money, the requirements have, in fact, led to an unnecessary waste of state and federal effort. States have had to produce excessive assurances and documentation to receive waivers, with the final rules recently issued by HHS calling for even more data and substantiation. Somewhere along the way the concept of state flexibility has been lost.

Before outlining our specific concerns about the way the waiver program is being administered, and how the problems can be eased, I would like to make one thing clear. The states are in total support of the concept of budget neutrality as it relates to this program. As the administrators of Medicaid, we would be derelict in our duty if we were not serving the needs of our clients in as cost-effective manner as possible.

The argument has been made by some that, left to our own devices, the states would massively expand the program by providing care to thousands who currently do not meet the eligibility criteria. Anyone who believes this assertion has not examined the financial situation of states lately, or had to defend a Medicaid budget to a state legislature. Even if "budget neutrality" were not spelled out in the statute, the states would support such a policy because of the realities we have to face today.

Much of the controversy now surrounding the waiver program is related to how budget neutrality is monitored and enforced. The states, as I have already said, agree with the concept. We have strong arguments, however, with the administration's method of implementing it.

Problems

Let me describe the major problems with the administration's current waiver policy.

First, the cost formula used to evaluate waiver requests rewards states that build nursing home beds and penalizes states that have controlled bed growth. In order to evaluate a waiver request, a comparison is made between the average cost of care estimated under the waiver and the average estimated cost of care if no waiver existed. This is a reasonable test and is called for in the statute. The problem is that in estimating what the population in need of long-term care services would be in lieu of the waiver, HCFA requires states to submit documentation on the number of beds that would be built if no waiver were granted. The documentation must be obtained from the certificate-of-need program in the state or, if such a program no longer exists, other "convincing data" on bed growth must be provided.

Using "number of beds to be built" as a surrogate measure of the population in need is a poor choice, at best. Not only does this measure fail to assess the need for care, it may do the exact opposite. If a state, in the interest of fiscal restraint, has limited, or put an outright freeze on, the nursing home beds it will allow to be built, it does not score well on this measure, even though the limit or freeze has increased the need for home or community care. On the other hand, a state that has not controlled the building of beds would be able to document more growth, and thus receive a waiver, despite probably having less need for one. The final rules, therefore, reward states for not controlling the growth of nursing home beds and penalize states that do--the very states that have the most need for alternative services.

Second, the final rule places a limit on total expenditures for home and community-based services under the waiver, a limit which imposes an unwarranted burden on the states and has no basis in the statute. The law clearly states that in order to receive a waiver a state must show that the average per capita expenditure on medical assistance in any fiscal year for individuals covered by waiver services does not exceed the average per capita expenditure that would have been incurred if the waiver had not been in effect. States are required to submit with the waiver request estimates of these figures, and a waiver is not granted until HCFA agrees with the estimates. This is all reasonable.

However, the final rule requires states to provide annual assurances that the actual total expenditure for home and community-based services will not exceed the amount estimated. Federal financial participation (FFP) is to be withheld if a state exceeds its estimate, and a state may have its waiver terminated, as well. We object to this leap beyond the requirements of the statute. The purpose of the waiver is to provide alternative services at an average cost that is less than or equal to the average cost of institutional care. According to HHS' interpretation of the law, a state could provide services in the community at an average cost below what it would have spent on institutional care but above the estimated average cost for community care and still be penalized under this criterion. This places the states, alone, at risk. In every other aspect of the Medicaid program, the financial responsibility and risks are shared by the federal government and the states. If a state has estimated the cost of the program in good faith, and HCFA has agreed with this estiamte, the state should not have to bear the entire financial burden, particularly if the intent of the statute (i.e., average community expenditures are to be lower than average institutional expenditures) has been met.

Third, the administrative handling of waiver requests, particularly the use of the 90-day clock for approval, has been so inconsistent that it has become a deterrent for states that may want to apply for a waiver. The final rule clarifies much of the policy HCFA will follow in approving waivers, but until now the requirements states had to meet to receive a waiver were in constant flux. Even with the final rules, some issues remain unresolved, the most notable being how the 90-day time-period is suspended whenever HCFA requests additional information from a state to document the state's waiver request. While this is reasonable for one or two additional requests, it becomes patently absurd when a state has to wait between 6 months and one year to receive approval, as some have.

Solutions

There are a variety of ways to improve the operation of the Medicaid waiver program. The states believe that any solutions, to be effective and viable, must both alleviate existing administrative problems and maintain budget neutrality.

A first step towards these goals has been taken by the House Energy and Commerce Committee. In that committee's amendments to the home and community-based program, modifications have been made to the policies being followed by HCFA--modifications which the states support. The most important of these changes would prohibit HCFA from limiting FFP simply because a state exceeded what it originally estimated it would spend on home and community-based services. The House committee has also clarified that when HCFA compares the cost of home and community-based care to the cost of institutional care, the comparison is to be between the average per capita cost of the former and the full average per capita cost of the latter. The purpose of this clarification is to counter an unwritten criterion, now operative in the federal approval process, which requires states to provide "waivered" services at 75 percent of the cost of institutional care.

While the states support these changes, we believe that more could be done. First, we would suggest that current statute clarify how the population in need of care is to be estimated. As I have already pointed out, HCFA's interpretation is that need can only be accurately projected by documenting the number of beds that would be built if no waiver were granted. The states think that a more accurate projection of need would be to count the number of individuals currently receiving institutional care under a state's Medicaid program and then index that number to the growth in the state's elderly population (for waivers involving the elderly), or the growth rate in the state's general population (for waivers involving the mentally retarded/developmentally disabled). This would be a more accurate measure of need than documented bed growth and would eliminate the perverse and expensive incentives that are created by using beds as a measure of need.

I would like to take this discussion even a step further, however, because there is a strong sentiment among the states that the best solution to the current problems in the waiver program would involve more than clarifying current policy. In a poll of state Medicaid agencies conducted by the Oregon Department of Human Resources, states overwhelmingly thought that we should move towards providing home and community-based services as a state option. This is an idea the states and various interest groups have brought to the Finance Committee before. Although it is often praised as a goal, it is just as often dismissed as too costly. We believe, however, that the idea is often dismissed too quickly. With the proper constraints, providing home and community-based services as a state option can be accomplished within the context of budget neutrality. Such an approach would not be simple, but it should be pursued if we are serious about finding alternatives to institutionalization. Providing publicly financed long term care services in this country is not an either/or choice, but a matter of deciding how involved the public sector will be and how necessary care can be provided efficiently. Closing the door on home and community-based care because of a myopic concern over an unsubstantiated explosion in the Medicaid budget, can only lead to the more costly provision of institutional care. This perverse result can be avoided if we continue to pursue home and community-based care in a constructive, efficient, and vigorous manner. A state option would be an important step in this direction.

Thank you for inviting me to testify today. I would be happy to answer any questions you might have.

STATEMENT OF MICHAEL PETIT, COMMISSIONER, MAINE DEPARTMENT OF HUMAN SERVICES, STATE OF MAINE, AUGUSTA, ME; ON BEHALF OF THE NATIONAL COUNCIL OF STATE HUMAN SERVICE ADMINISTRATORS

Mr. **Petit**. My name is Michael Petit. I am a commissioner of Maine's Department of Human Services and the chairman of the National Council of State Human Services Administrators.

My written testimony today speaks directly to the deficit reduction issues that are before you. However, I would like to focus my attention and testimony on a problem faced by the 50 States that is contributing to the Nation's long-term social deficits and which requires more assistance from our Federal Government.

It is our view that millions of American families are no longer able to provide a protective environment to their children.

At the very time that economic indicators are going up, social indicators affecting children are going down. I would like to cite a few examples for you.

The Congressional Research Service shows a stunning increase in the number of children living in poverty to an all-time high of some 13 million, the highest since 1964 and 1965.

In 45 of our States, verified cases of physical and sexual abuse against children have increased, and in my State over the last 2 years, there has been a 300-percent increase in the number of cases of sexual abuse against children.

We know that millions of children across the country are living in substandard housing with no relief in sight.

We know that poor children, according to one study, are dying at a rate 300 percent greater than nonpoor children.

Out of wedlock births are up. Infant mortality rates on the rise in some cities, and we know that in Washington, DC, the Nation's Capital, we experience the highest rate of infant mortality in the Nation.

The long-term consequences of all this are increased dependency, alcoholism, and mental illness, and criminal behavior; and what we are seeing is that the young child victims of today are becoming the victimizers of tomorrow. One of the most enlightening figures that I have come across is one put out by the Department of Justice, which shows that the number of prisoners in the country doubled from 1972 to 1984 from 200,000 to 460,000, which is a rate of incarceration that may be the highest of nonpolitical prisoners in the world.

We also know that these prisoners are young and overwhelmingly from the families that we are talking about.

The States fully recognize that the Federal Government alone cannot solve these problems. Our council has just adopted this issue as its top priority for the next couple of years, and many of the States are now taking action to address these problems.

But on behalf of those whose job it is to spend and administer the funds that you allocate, I can tell you that we are not making much of an inroad into these problems and they are getting worse.

Let me just outline for you a few measures we suggest that you consider, both in the short term and in the long term.

First is an integrated national policy is needed to address the problems of children and their families. Coordination of programs, funding, and strategies at the Federal level is missing. It is essential if the States are to do their jobs.

We ask that you consider creating some kind of a congressional commission to review this whole issue.

Second, Congress should begin to reduce the wide variances and benefits from State to State in the AFDC, Food Stamp, and Medicaid Programs. Meeting the basic needs of children should be more than a function of which State they happen to be born in.

Third, a fundamental overhaul of the AFDC Program is needed. When first established in the 1930's, the primary beneficiaries were widows and their children. Today's population is vastly different.

AFDC needs to be much more closely tied to other Federal programs like education and work.

And finally, the AFDC Program should also be indexed.

Fourth, the Congress should help the States realistically address the problems of teen pregnancy. A recent study in Illinois shows annual costs associated with teen pregnancy of more than $700 million.

Also, our Nation's teen pregnancy rate is twice the rate of France, Sweden, England, or the Netherlands. Indeed, our teenage abortion rate exceeds their teen pregnancy rates.

Fifth, we believe that child care should emerge as a funding priority if children are to be adequately supervised while their parents work.

In addition, this problem could be helped by encouraging or requiring fringe benefits for part-time work, an action that many of us believe would enable parents to better care for their children.

Sixth, tax policy must be changed to enable families themselves to better provide for their own financial needs. According to the Congressional Budget Office, one-third of average family income was subject to Federal taxation in 1948. Today, two-thirds are subject to taxation.

We are certainly encouraged that Congress is considering tax reform that addresses the question of family taxation and dependent deductions.

And seventh, the services you support must be redirected to emphasize a more preventive and early intervention focus. We are all better served if families are enabled to be more self-sufficient.

Early intervention services are less expensive, more effective, and most importantly, less intrusive into family life.

In summary, the problems of our children are worsening. The entire Nation is paying the price, and we need a renewed national commitment to invest in their well-being if long-term social as well as financial deficits are to be relieved.

The CHAIRMAN. Thank you, Mr. Petit. Mr. Fulton.

[The prepared written statement of Mr. Petit follows:]

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TESTIMONY OF

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OF THE

AMERICAN PUBLIC WELFARE ASSOCIATION

AND

COMMISSIONER, MAINE DEPARTMENT OF HUMAN SERVICES

FOR THE

COMMITTEE ON FINANCE

HEARING ON DEFICIT REDUCTION OPTIONS

September 13, 1985

Good morning Mr. Chairman, and members of the committee. I am Michael R. Petit, commissioner of the Maine Department of Human Services, and chairman of the National Council of State of Human Services Administrators of the American Public Welfare Association. Today I come before you to comment on proposed actions to reduce the federal deficit. As the people who administer Medicaid, AFDC, social services, and other human service programs, we have a keen interest in the finance committee's delibrations, and are thankful for this opportunity to testify. Before making specific comments on deficit-reduction proposals, I would like to offer some general thoughts on the direction state human service administrators believe programs for the poor should take now and in the future, given the continuing gap between federal spending and revenues.

The deficit has been characterized as a "mortgage on our future" which is coming due with alarming speed. We accept both this characterization and the necessity to reduce that mortgage. However, we also believe that a deficit reduction plan will be counterproductive if it erodes basic life support programs, services to reduce dependency, and efforts to enhance the life options of the poor, especially poor children. Such a strategy will surely undermine our only real hope for a mortgage-free future--a healthy and self-sufficient population.

Programs for low-income families and children, while constituting less than 10% of federal expenditures, have sustained 30% of all the budget cuts in the last four years at a time when poverty was increasing. No significant dent can be made in our nation's $200 billion deficit by further cutbacks in this tenth of the federal budget. Nor should it be made, if we want to avoid the further impoverishment of disadvantaged children and their families. In this connection, we applaud the budget compromise approved by Congress in late

JULY. THE COMPROMISE PROTECTS PROGRAMS FOR LOW-INCOME AMERICANS WHILE MAKING SIGNIFICANT PROGRESS IN REDUCING THE RED INK THAT THREATENS THE ECONOMIC GROWTH ON WHICH ALL SECTORS OF OUR SOCIETY DEPEND.

THOUGH STATE ADMINISTRATORS STRONGLY BELIEVE THAT FEDERAL SUPPORT FOR THE POOR MUST BE PRESERVED, WE ALSO RECOGNIZE THE INCREASING NEED TO DESIGN AND IMPLEMENT PROGRAMS THAT REDUCE DEPENDENCY AND MOVE PEOPLE TOWARD SELF-SUFFICIENCY. THUS, OUR COUNCIL, IN A RECENT POLICY STATEMENT, CALLED ON ALL STATE HUMAN SERVICE AGENCIES TO STRENGTHEN THEIR COMMITMENTS TO RESPOND EFFECTIVELY TO THE BASIC NEEDS OF LOW-INCOME FAMILIES, TO HELP PROTECT CHILDREN FROM ABUSE AND NEGLECT, AND TO HELP MEMBERS OF POOR FAMILIES TAKE FULL ADVANTAGE OF THE TRAINING, EDUCATIONAL, AND EMPLOYMENT OPPORTUNITIES THEY NEED TO ACHIEVE INDEPENDENCE. WE HAVE ESPECIALLY PLEDGED TO PLACE INCREASED EMPHASIS ON EFFORTS TO INTERVENE EARLY IN THE PROBLEMS THAT AFFLICT LOW-INCOME FAMILIES AND TO PREVENT SUCH PROBLEMS FROM OCCURRING WHENEVER AND WHEREVER POSSIBLE. WE REALIZE THESE ARE DIFFICULT TASKS TO FULFILL, BUT WE ALSO KNOW THAT THERE IS NO OTHER CHOICE IF WE ARE TO BE SERIOUS ABOUT HELPING AMERICA'S CHILDREN BECOME PRODUCTIVE ADULTS.

ADMITTEDLY, STATE HUMAN SERVICE AGENCIES CANNOT ACHIEVE THE GOALS I HAVE JUST STATED ON THEIR OWN. WE WANT THE FEDERAL GOVERNMENT AND THE PRIVATE SECTOR TO BE OUR WILLING AND ACTIVE PARTNERS. TOWARD THIS END, WE HAVE INITIATED A PROJECT, UNDER THE AUSPICES OF THE AMERICAN PUBLIC WELFARE ASSOCIATION, TO CONDUCT OVER THE NEXT 18 MONTHS: (1) A FULL RE-EXAMINATION OF EXISTING HUMAN SERVICE PROGRAMS COMPARED TO OTHER MEANS OF ASSURING BASIC LIFE SUPPORT FOR THE POOR AND PROVIDING ALTERNATIVES TO DEPENDENCY; (2) AN ASSESSMENT OF THE EFFECTS OF TAX POLICIES ON THE CAPACITY OF LOW-INCOME FAMILIES TO SUPPORT THEMSELVES; AND (3) A STRUCTURED AND CONTINUOUS EXCHANGE OF INFORMATION AMONG

STATE AND FEDERAL OFFICIALS AND PRIVATE SECTOR LEADERS ON SUCCESSFUL HUMAN SERVICE PROGRAMS--TO BETTER DETERMINE WHAT WORKS AT WHAT COST.

IN THE CONTEXT OF THIS EFFORT, THERE ARE CERTAIN PRINCIPLES THAT MY COLLEAGUES AND I BELIEVE SHOULD GUIDE CONGRESSIONAL ACTION ON THE FY 86 BUDGET:

FIRST, RESOURCES SHOULD NOT BE FURTHER REDUCED AND ELIGIBILITY SHOULD NOT BE FURTHER RESTRICTED IN THE BASIC PROGRAMS THAT SUSTAIN HUMAN LIFE SUCH AS AFDC, MEDICAID, SOCIAL SERVICES, AND EMPLOYMENT AND TRAINING PROGRAMS.

SECOND, CONSIDERATION SHOULD BE GIVEN TO ADDITIONAL EFFORTS TO PROVIDE SPECIAL SERVICES TO PREVENT ADOLESCENT PREGNANCY AND HELP TEEN MOTHERS AND FATHERS AND THEIR CHILDREN.

THIRD, INCREASED EMPHASIS SHOULD BE PLACED IN FEDERAL POLICY ON PREVENTING FAMILY VIOLENCE AND CHILD ABUSE AND NEGLECT.

AND FOURTH, WELFARE RECIPIENTS SHOULD BE PROVIDED GREATER ACCESS TO JOB TRAINING AND JOB PLACEMENT PROGRAMS.

WITH THIS DISCUSSION AS BACKGROUND, I WOULD NOW LIKE TO MOVE TO OUR VIEWS ON SPECIFIC BUDGET PROPOSALS AFFECTING THE MEDICAID, AFDC, AND SOCIAL SERVICE PROGRAMS.

MEDICAID

LET ME BEGIN MY COMMENTS ON MEDICAID BY COMMENDING THE SENATE'S DECISION TO, IN EFFECT, REJECT THE PROPOSAL TO CAP MEDICAID SPENDING. SUCH AN ARBITRARY LIMIT ON BENEFIT PAYMENTS WOULD UNDERMINE THE MEDICAID PROGRAM'S PURPOSE OF MAKING HEALTH CARE AVAILABLE TO THE POOR, WHILE PROVIDING NO SIGNIFICANT MEANS OF EFFECTIVELY CONTROLLING COSTS. WE ARE ALSO PLEASED THAT THE COMPROMISE ON THE BUDGET DOES NOT APPEAR TO ASSUME THE ADMINISTRATION'S RECOMMENDATION TO FINANCE STATE MANAGEMENT OF MEDICAID (AS WELL AS AFDC AND FOOD STAMPS) THROUGH BLOCK GRANTS. THIS PROPOSAL WOULD PLACE AN UNFAIR FINANCIAL BURDEN ON THE STATES IN THE OPERATION OF PROGRAMS THAT ARE AN INTERGOVERNMENTAL RESPONSIBILITY.

AMONG THE MEDICAID PROPOSALS THAT WE UNDERSTAND THE FINANCE COMMITTEE IS ACTIVELY CONSIDERING, ONE OF THE MORE IMPORTANT CONCERNS IMPROVING COLLECTIONS FROM THIRD PARTY INSURERS. IN MARCH, A PANEL REPRESENTING STATE HUMAN SERVICE AGENCIES TESTIFIED BEFORE YOUR COMMITTEE IN SUPPORT OF ENHANCED EFFORTS IN THE IDENTIFICATION AND RECOVERY OF THIRD PARTY LIABILITY. AS HAS BEEN DOCUMENTED BY GAO, MORE EFFORT CAN AND SHOULD BE MADE IN THIS AREA. WE ALSO AGREED THAT A COST-AVOIDANCE SYSTEM--ONE THAT SCREENS FOR AVAILABLE THIRD PARTY COVERAGE BEFORE PAYMENT TO THE PROVIDER--IS GENERALLY MORE COST-EFFECTIVE THAN A PAY-AND-CHASE SYSTEM--WHERE THE STATE PAYS THE BILL AND THEN SEEKS OUT THE THIRD PARTY PAYER.

HOWEVER, CONSTRUCTIVE IMPROVEMENTS IN THIRD PARTY LIABILITY WILL NOT OCCUR IF STATUTORY CHANGES SPELL OUT THE PROCESS STATES MUST FOLLOW, AS WELL AS THE SPECIFIC OUTCOMES STATES MUST ACHIEVE THROUGH THIS PROCESS. WE BELIEVE IT MAKES SENSE TO REQUIRE STATES TO MEET CERTAIN PROCEDURAL MANDATES, SUCH AS

HAVING ELIGIBILITY WORKERS ASK QUESTIONS REGARDING THIRD PARTY LIABILITY AT THE TIME AN INDIVIDUAL APPLIES FOR MEDICAID AND OBLIGATING STATES TO SUBMIT A THIRD PARTY LIABILITY PLAN TO HHS FOR ITS APPROVAL. IF THESE REQUIREMENTS ARE DEFINED IN STATUTE, HOWEVER, A STATE SHOULD NOT THEN BE EVALUATED ON THE RESULTS OF THE PROCESS. AS WE STATED IN MARCH, TRYING TO ESTABLISH A COMPARATIVE EVALUATION OF OUTCOMES REGARDING THIRD PARTY LIABILITY, AS IS DONE IN THE ELIGIBILITY QUALITY CONTROL SYSTEM, WOULD CAUSE NUMEROUS PROBLEMS. PREVIOUSLY, OMB, HCFA, AND THE STATES MUTUALLY AGREED TO DO AWAY WITH A THIRD PARTY LIABILITY QUALITY CONTROL SYSTEM BECAUSE IT PROVED INEFFECTIVE AND PROVIDED LITTLE BASIS FOR VALIDLY COMPARING THE STATES. AN INCREASED EFFORT IN THIRD PARTY LIABILITY IS WARRANTED, BUT IT SHOULD BE IMPLEMENTED IN A CONSTRUCTIVE FORM IF THE EXPECTED FEDERAL SAVINGS ARE TO BE OTHER THAN ILLUSORY.

ANOTHER MEDICAID ISSUE OF INTEREST TO THE STATES IS THE LACK OF FLEXIBILITY IN PROVIDING SERVICES. IN THIS REGARD, WE SUPPORT THE PROVISION IN S.505 THAT WOULD ALLOW STATES MORE LATITUDE IN MAKING SERVICES AVAILABLE TO PREGNANT WOMEN. CURRENT PROGRAM GUIDELINES REQUIRE A STATE THAT PROVIDES A SERVICE TO PREGNANT WOMEN TO ALSO FURNISH THAT SERVICE TO ALL PARTICIPANTS IN THE MEDICAID PROGRAM. IT WOULD ENHANCE STATE AGENCIES' ABILITY TO MEET THE HEALTH CARE NEEDS OF PREGNANT WOMEN IF THIS REQUIREMENT WERE REMOVED.

I WOULD ALSO LIKE TO COMMENT ON TWO MEDICAID PROPOSALS THAT HAVE BEEN ADOPTED BY THE HOUSE ENERGY AND COMMERCE COMMITTEE IN H.R. 3101. THE FIRST IS A RECOMMENDATION TO COUNT AS AN ASSET ANY TRUST FROM WHICH AN INDIVIDUAL RECEIVES INCOME AS DETERMINED BY THE TRUSTEES IN CHARGE. SUCH TRUSTS ARE A GROWING PROBLEM IN MEDICAID, BECAUSE MANY INDIVIDUALS IN THE MIDDLE OR UPPER LEVELS OF INCOME ARE OBTAINING ELIGIBILITY AFTER THEY PLACE THEIR ASSETS IN A

TRUST, YET STILL RECEIVE INCOME FROM THOSE ASSETS. MEDICAID IS A PROGRAM FOR THE ECONOMICALLY DISADVANTAGED AND MUST OPERATE WITH LIMITED FUNDS. STATE HUMAN SERVICES ADMINISTRATORS BELIEVE THAT WHENEVER A PERSON OBTAINS MEDICAID ELIGIBILITY BY SHIFTING ASSETS TO ONE OF THESE TRUSTS, OTHER PEOPLE MORE IN NEED OF MEDICAL ASSISTANCE MUST GO WITHOUT. FOR THIS REASON WE STRONGLY SUPPORT THE HOUSE PROVISION. THE SECOND PROPOSAL BY THE ENERGY AND COMMERCE COMMITTEE WOULD MAKE ADOPTION ASSISTANCE AND FOSTER CARE CHILDREN UNDER TITLE IV-E ELIGIBLE FOR MEDICAID IN THE STATE IN WHICH THEY RESIDE. CURRENTLY, MANY CHILDREN WHO ARE PLACED IN A DIFFERENT STATE THAN THE ONE FROM WHICH THEY RECEIVE THEIR ASSISTANCE PAYMENTS EXPERIENCE DIFFICULTY IN OBTAINING MEDICAID SERVICES IN THEIR STATE OF RESIDENCE. THIS IS BECAUSE THE PROVIDERS SUCH A CHILD SEEKS CARE FROM MUST ACCEPT THE MEDICAID CARD FROM THE STATE FROM WHICH THE CHILD WAS PLACED, BILL THIS OTHER STATE WITH FORMS THEY ARE UNFAMILIAR WITH, AND FIGURE OUT WHICH SERVICES ARE COVERED UNDER MEDICAID IN THAT OTHER STATE. THE HOUSE PROPOSAL, WHICH IS SUPPORTED BY THE CHILDREN'S DEFENSE FUND, AS WELL AS APWA, WOULD REMOVE THESE ADMINISTRATIVE BARRIERS AND IMPROVE MEDICAID ACCESS FOR MANY NEEDY CHILDREN, AT NO ADDITIONAL COST TO THE FEDERAL GOVERNMENT.

BEFORE TURNING TO AFDC, I WANT TO MENTION ONE LAST MEDICAID ITEM WHICH THE FINANCE COMMITTEE WILL BE CONSIDERING. LAST YEAR, CONGRESS AGREED TO PLACE A MORATORIUM ON CERTAIN MEDICAID ELIGIBILITY ERRORS RELATED TO THE MEDICALLY NEEDY UNTIL THE RELEVANT CONTROVERSIAL POLICIES COULD BE STUDIED AND ACTION TAKEN TO CLARIFY THEM. HCFA HAS CHOSEN TO IGNORE THIS MORATORIUM. THE HOUSE BILL ON MEDICARE AND MEDICAID FRAUD AND ABUSE, H.R. 1868, CONTAINS AN AMENDMENT THAT WOULD CLARIFY THE INTENT OF THE MORATORIUM IN ORDER TO ENSURE ITS ENFORCEMENT. WE HOPE THAT YOU WILL GO ALONG WITH THE HOUSE ON THIS PROVISION, AS STATES ARE CURRENTLY BEING PUT AT FINANCIAL RISK FOR POLICIES

BOTH CONGRESS AND THE STATES AGREE NEED CLARIFICATION.

AFDC

THE ADMINISTRATION HAS PROPOSED FOUR CHANGES IN THE AFDC PROGRAM. STATE ADMINISTRATORS DO NOT SUPPORT ANY OF THESE PROPOSALS, WHICH WE BELIEVE WOULD ACHIEVE MINIMAL SHORT-TERM SAVINGS AT THE EXPENSE OF POOR CHILDREN AND THEIR FAMILIES.

OVER THE PAST SEVERAL YEARS, THE STATES HAVE MADE SIGNIFICANT PROGRESS IN ESTABLISHING PROGRAMS DESIGNED TO MOVE WELFARE RECIPIENTS OFF THE ROLLS AND INTO THE LABOR MARKET. THE ADMINISTRATION IS RECOMMENDING A NEW SET OF WORK PROGRAM REQUIREMENTS WHICH, IN OUR JUDGMENT, WILL UNDERMINE THIS PROGRESS. THE "WELFARE AND WORK OPPORTUNITIES" PROPOSAL WOULD, SPECIFICALLY, CURTAIL STATES' ABILITY TO EFFECTIVELY TARGET EMPLOYMENT AND TRAINING EFFORTS, DISCOURAGE WORK PROGRAM INNOVATIONS, AND INCREASE AND SHIFT OPERATING COSTS TO THE STATES.

UNDER THIS SCHEME FUNDING FOR WIN WOULD BE ELIMINATED. NEVERTHELESS, STATES WOULD BE REQUIRED TO EXPAND WORK PROGRAM ACTIVITIES TO APPLICANTS AND ADDITIONAL CATEGORIES OF RECIPIENTS, AND TO ENSURE THAT THE MAJORITY OF ELIGIBLE PARTICIPANTS ARE ACTIVELY INVOLVED IN A WORK ACTIVITY ON A REGULAR BASIS.

WE DO NOT IN THE LEAST OBJECT IN PRINCIPLE TO EXPANDING WORK PROGRAMS. HOWEVER, WITHOUT SUFFICIENT FEDERAL RESOURCES, EXPANSION WILL ONLY LEAD TO INEFFECTUAL PROGRAMS AND LIMIT STATES' ABILITY TO REDUCE WELFARE DEPENDENCY AND ITS ASSOCIATED COSTS. INDEED, THE ADMINISTRATION'S SCHEME WOULD REQUIRE SPENDING MORE MONEY THAN AT PRESENT, THE DIFFERENCE BEING THAT STATES WOULD

HAVE TO COVER THE BULK OF THE INCREASED COST THEMSELVES. DELAWARE, FOR EXAMPLE, HAS ESTIMATED THAT IT WOULD HAVE TO SPEND $4.2 MILLION TO OPERATE THE ADMINISTRATION'S WORK PROGRAM IN THE FIRST YEAR ALONE--3.5 TIMES ITS CURRENT COSTS. MISSOURI WOULD HAVE TO DEVOTE AN EXTRA $12 MILLION TO ACCOMMODATE RECIPIENTS NOT NOW PARTICIPATING IN A WORK ACTIVITY. THESE COSTS WOULD ESCALATE AS THE REQUIRED PARTICIPATION LEVELS INCREASE IN SUBSEQUENT YEARS.

FOUR YEARS AGO, CONGRESS GRANTED STATES MORE FLEXIBILITY TO DESIGN AND OPERATE COST-EFFECTIVE WORK PROGRAMS FOR THE WELFARE POPULATION. IN THE SHORT TIME SINCE THEN, STATES HAVE TAKEN RESPONSIBLE ADVANTAGE OF THE DISCRETION THEY HAVE BEEN GIVEN TO DEVELOP INNOVATIVE WORK-RELATED ACTIVITIES--RANGING FROM JOB SEARCH CLUBS TO SKILLS TRAINING TO WAGE SUPPLEMENTATION. DESPITE LIMITED DOLLARS, STATES HAVE HAD MEASURABLE SUCCESS WITH THEIR PROGRAMS. NATIONWIDE, IN 1984 MORE THAN 350,000 AFDC RECIPIENTS PARTICIPATING IN WIN/WIN DEMONSTRATIONS FOUND JOBS. THE RESULTING SAVINGS TOTALLED $587 MILLION, MORE THAN DOUBLE THE $260 MILLION IN FEDERAL MONEY INVESTED IN WIN FUNDING TO STATES FOR THIS PERIOD. FEW FEDERAL PROGRAMS PROBABLY COME CLOSE TO MATCHING THIS KIND OF PERFORMANCE--TWO DOLLARS SAVED FOR EVERY FEDERAL DOLLAR INVESTED. BY COMPARISON, THE ADMINISTRATIONS'S PROPOSAL WOULD YIELD NET SAVINGS OF ONLY $150 MILLION, EVEN AFTER CONSIDERING THE $270 MILLION ATTRIBUTED TO ELIMINATING WIN. RATHER THAN SPOIL A GOOD THING, EFFORTS SHOULD BE MADE TO BUILD ON THE PROGRESS STATES HAVE ALREADY MADE. STABILIZING FUNDING FOR WIN/WIN DEMONSTRATIONS AND MAKING THE WIN DEMONSTRATION PROGRAM A PERMANENT STATE OPTION WOULD BE TWO IMMEDIATE STEPS CONGRESS COULD TAKE IN THIS DIRECTION.

BESIDES ITS WORK PROGRAM PROPOSAL, THE ADMINISTRATION HAS RECOMMENDED SHARPLY RESTRICTING AFDC ELIGIBILITY FOR MINOR MOTHERS AND ENDING A PARENT'S AFDC

BENEFITS WHEN THE YOUNGEST CHILD REACHES AGE 16. THESE PROPOSALS WOULD ALSO SHIFT COSTS TO STATES, SINCE STATES OFTEN END UP FINANCING SUPPORT FOR THOSE WHO LOSE AFDC ELIGIBILITY. THE RESTRICTION ON MINOR MOTHERS ELIGIBILITY WOULD BE INSENSITIVE TO THE VARYING CIRCUMSTANCES IN WHICH MINOR MOTHERS FIND THEMSELVES AND WOULD ADD TO THE COMPLEXITY OF ELIGIBILITY DECISIONS, AS WORKERS WOULD HAVE TO DETERMINE IN EACH CASE WHETHER AN EXCEPTION TO THE RESTRICTION COULD BE GRANTED. AS FOR THE PROPOSAL TO EXCLUDE THE NEEDS AND INCOME OF THE PARENT OR CARETAKER RELATIVE WHEN THE YOUNGEST CHILD REACHES AGE 16, WE BELIEVE THIS COULD ENCOURAGE TEENAGERS TO LEAVE SCHOOL TO SUPPORT THEIR FAMILY. IT WOULD ALSO SHUT OFF ASSISTANCE TO PARENTS WHO OFTEN HAVE BEEN OUT OF THE LABOR FORCE FOR ALL OR MOST OF THEIR CHILD-REARING YEARS AND WHO CONTINUE TO NEED SUPPORT IN MAKING THE TRANSITION TO PAID EMPLOYMENT. BOTH OF THE RECOMMENDATIONS TO FURTHER RESTRICT ELIGIBILITY TRADE-OFF THE PROVISION OF NEEDED ASSISTANCE FOR SHORT-TERM SAVINGS. THE RESULT WOULD BE TO INCREASE THE LIKELIHOOD OF EVEN LARGER LONG-TERM PUBLIC COSTS AS THOSE RECIPIENTS FORCED OFF THE ROLLS DO NOT RECEIVE THE SUPPORTS THAT CAN ENABLE THEM TO BECOME SELF-SUFFICIENT.

IN OUR VIEW, MAKING PROGRAM MODIFICATIONS THAT ENHANCE THE STATES' ABILITY TO BREAK THE CYCLE OF DEPENDENCY--SUCH AS IMPROVING EMPLOYMENT AND TRAINING EFFORTS AND PERMITTING SERVICES TO BE BETTER TARGETED--STAND THE BEST CHANCE OF PRODUCING THE SIGNIFICANT LONG-TERM DEFICIT REDUCTIONS WE ALL WANT. CONGRESSIONAL ACTION TO ASSIST STATES IN THEIR EFFORTS TO ADDRESS THE PROBLEM OF TEEN PREGNANCY, FOR EXAMPLE, COULD HELP REDUCE FEDERAL AND STATE WELFARE COSTS. NATIONALLY, MORE THAN HALF OF ALL AFDC EXPENDITURES ARE ESTIMATED TO GO TO FAMILIES HEADED BY SINGLE-WOMEN WHO WERE TEENAGERS WHEN THEY HAD THEIR FIRST CHILD. RECOGNIZING THE IMPORTANCE OF ADDRESSING THIS PROBLEM, THE NATIONAL COUNCIL OF STATE HUMAN SERVICE ADMINISTRATORS, WITH THE HELP OF

PRIVATE FOUNDATIONS, HAS BEGUN A COMPREHENSIVE EFFORT TO IDENTIFY EFFECTIVE METHODS TO PREVENT ADOLESCENT PREGNANCY AND HELP ALREADY PREGNANT OR PARENTING TEENS BECOME ECONOMICALLY SELF-SUFFICIENT. MODEST FEDERAL FUNDING TO ENABLE STATES TO IMPLEMENT TEEN PREGNANCY PROGRAMS AIMED AT THE AFDC POPULATION WOULD PROVIDE A MAJOR BOOST TO PUBLIC SECTOR EFFORTS IN THIS AREA. ALTHOUGH SUCH AN INITIATIVE WOULD ENTAIL INITIAL START-UP COSTS, IT HOLDS THE PROMISE OF ACHIEVING SUBSTANTIAL SAVINGS IN THE LONG RUN.

BEFORE MOVING ON TO A DISCUSSION OF QUALITY CONTROL, I'D ALSO LIKE TO COMMENT BRIEFLY ON A PROPOSAL RECENTLY OFFERED BY SEN. HEINZ, S.1491, TO REQUIRE EACH STATE TO ESTABLISH A STANDARD AFDC MANAGEMENT INFORMATION SYSTEM, KNOWN AS FAMIS, BY OCT. 1, 1988. STATE HUMAN SERVICE ADMINISTRATORS QUESTION THE NECESSITY OF A FEDERAL MANDATE. MORE THAN 40 STATES ARE ALREADY IN SOME STAGE OF FAMIS DEVELOPMENT, AND THE REMAINING STATES HAVE ALTERNATIVE AUTOMATED MANAGEMENT INFORMATION SYSTEMS WHICH THEY HAVE DETERMINED TO BE EFFECTIVE. IT MAKES LITTLE SENSE FOR A STATE LIKE NEW YORK, WHICH SPENT MORE THAN $176 MILLION OVER 5 YEARS IN DEVELOPING A USEFUL INFORMATION SYSTEM, TO REVAMP THAT SYSTEM TO MEET FEDERAL SPECIFICATIONS THAT ARE NOT NECESSARILY ANY BETTER. WHILE WE AGREE THAT AUTOMATION IS CRITICAL TO SOUND PROGRAM MANAGEMENT AND ERROR REDUCTION EFFORTS, FAMIS IS NOT THE ONLY APPROACH TO AUTOMATION THAT WILL ENABLE A STATE TO ACHIEVE POSITIVE OUTCOMES. STATE-SPECIFIC SYSTEMS MAY WORK JUST AS WELL.

QUALITY CONTROL

IN THE CONTEXT OF FISCAL RESPONSIBILITY, MY REMARKS MUST COVER THE NEED FOR QUALITY CONTROL AND RESPONSIBLE MANAGEMENT IN THE AFDC AND MEDICAID PROGRAMS. INTEGRAL TO THE EFFICIENT MANAGEMENT OF THE STATE AND FEDERAL FUNDS INVESTED

IN THESE PROGRAMS IS A FAIR AND RELIABLE QUALITY CONTROL SYSTEM.

THE PROBLEM POSED BY CURRENT QUALITY CONTROL POLICIES IN THESE PROGRAMS IS A SERIOUS ONE. THE EXISTING QUALITY CONTROL SYSTEM PROVIDES NEITHER AN ACCURATE NOR AN EQUITABLE MEASURE OF STATE PERFORMANCE. NONETHELESS, IT IS THIS FLAWED SYSTEM WHICH IS THE BASIS FOR THE ASSESSMENT OF MILLIONS OF DOLLARS IN FISCAL PENALTIES AGAINST THE STATES. STATE EFFORTS TO RUN THE AFDC AND MEDICAID PROGRAMS FAIRLY AND EFFICIENTLY CAN ONLY BE UNDERMINED BY QUALITY CONTROL AS IT NOW OPERATES. INSTEAD OF STRENGTHENING THESE PROGRAMS, QUALITY CONTROL AND THE FISCAL PENALTIES IT GENERATES MAY WELL FORCE THE STATES TO CURTAIL BENEFITS AS WELL AS THE VERY ADMINISTRATIVE IMPROVEMENTS NEEDED FOR FURTHER ERROR REDUCTION.

I WANT TO MAKE IT CLEAR THAT STATE HUMAN SERVICE ADMINISTRATORS, NO LESS THAN THE FEDERAL GOVERNMENT, ARE FIRMLY COMMITTED TO THE CONCEPT OF QUALITY CONTROL. IT IS FOR THIS REASON THAT WE HAVE BEEN URGING CONGRESS TO ADOPT REFORMS TO IMPROVE THAT SYSTEM. WE CONTINUE TO STRIVE FOR THE HIGHEST LEVEL OF PAYMENT ACCURACY OF WHICH OUR AGENCIES ARE CAPABLE, SINCE WE, LIKE YOU, BELIEVE THAT LIMITED FEDERAL AND STATE PUBLIC ASSISTANCE FUNDS SHOULD GO ONLY TO RECIPIENTS WHO MEET THE ELIGIBILITY REQUIREMENTS. IT IS TOWARDS THIS END THAT WE HAVE MADE SUBSTANTIAL INVESTMENTS IN OUR EFFORTS TO DETECT, CORRECT AND PREVENT ERRORS, AND TO MODERNIZE MANAGEMENT OF THESE PROGRAMS SO THAT THE OPPORTUNITY FOR ERROR IS MINIMIZED. AS A RESULT, BOTH AFDC AND MEDICAID ERROR RATES HAVE DECLINED SUBSTANTIALLY. THE NATIONAL AFDC ERROR RATE DROPPED BY MORE THAN 50 PERCENT IN THE LAST DECADE--FROM 16.5 PERCENT TO 6.5 PERCENT, WHILE THE MEDICAID ERROR RATE HAS FALLEN FROM 4.9 PERCENT IN 1973 (THE FIRST YEAR ITS QUALITY CONTROL SYSTEM WAS IN PLACE) TO 2.5 PERCENT.

IRONICALLY, AS STATES CONTINUE TO MAKE PROGRESS IN ERROR REDUCTION, FISCAL PENALTIES CONTINUE TO AMASS. TO DATE, THERE ARE OVER $69 MILLION IN SANCTIONS PENDING IN THE AFDC PROGRAM, WITH SANCTIONS EXPECTED TO ADD UP TO $1.4 BILLION BY FY 88. IN MEDICAID THERE ARE OVER $75 MILLION IN PENALTIES PENDING, WITH OVER $14 MILLION ACTUALLY HAVING BEEN PROSPECTIVELY WITHHELD; SANCTIONS IN THE HEALTH CARE PROGRAM ARE EXPECTED TO EQUAL ROUGHLY $240 MILLION BY FY 88. WHILE THE PROSPECT OF LOSING FEDERAL FUNDS IS NOT ONE THAT ANY STATE WOULD WELCOME, WE ARE NOT ASKING TO BE EXONERATED FROM PENALTIES. WHAT WE WANT IS TO HAVE OUR PERFORMANCE MEASURED BY AN EQUITABLE AND ACCURATE SYSTEM. IT IS ONE THING TO PENALIZE BASED ON FAIR AND STATISTICALLY SOUND PROCEDURES, AND QUITE ANOTHER TO DO SO, AS IS NOW THE CASE, USING A PROCESS THAT IS INEQUITABLE, UNRELIABLE, AND OF DECREASING VALUE IN FACILITATING BETTER MANAGEMENT. THE FURTHER CURTAILMENT OF ERRORS DEPENDS NOT ON SUBJECTING STATES TO PUNITIVE AND ARBITRARY FISCAL PENALTIES BUT ON RESTORING CONFIDENCE AND RELIABILITY IN THE QUALITY CONTROL SYSTEM--TO MAKE IT TRULY A USEFUL MANAGEMENT TOOL.

CHANGES NEED TO THE MADE TO REMEDY THE FOLLOWING FLAWS IN THE CURRENT QUALITY CONTROL SYSTEMS FOR AFDC AND MEDICAID:

1) THE IMPACT ON ERROR RATES OF SOCIOECONOMIC, GEOGRAPHIC, AND PROGRAM DIFFERENCES AMONG STATES IS NOT TAKEN INTO CONSIDERATION.

2) STATE ERROR RATES CAN BE OVERSTATED BECAUSE THE MIDPOINT, RATHER THAN THE LOWER END OF THE RANGE WITHIN WHICH A STATE'S TRUE ERROR RATE IS STATISTICALLY CALCULATED TO FALL, IS USED TO DETERMINE THE STATE ERROR RATE.

3) THE EFFECT OF FREQUENTLY CHANGING AND COMPLEX FEDERAL POLICIES ON ERRORS IN NOT TAKEN INTO ACCOUNT.

4) FINAL ERROR RATE DATA ARE OFTEN GENERATED TOO LATE TO BE HELPFUL TO STATE DEVELOPMENT OF CORRECTIVE MEASURES.

5) THE DIFFERENCES BETWEEN AGENCY-CAUSED ERRORS AND CLIENT-CAUSED ERRORS ARE NOT RECOGNIZED IN CALCULATING FISCAL PENALTIES.

6) COST-EFFECTIVENESS OF FURTHER ERROR REDUCTION EFFORTS BY STATES IS NOT SUFFICIENTLY CONSIDERED.

AN ADDITIONAL PROBLEM EXISTING EXCLUSIVELY IN THE AFDC PROGRAM, IS THAT STATES ARE PENALIZED FOR "TECHNICAL ERRORS"--PROCEDURAL MISTAKES THAT DO NOT INVOLVE ACTUAL MISPAYMENTS. THESE TECHNICAL ERRORS CAN RANGE FROM 1 TO 2 PERCENTAGE POINTS OF A STATE'S ERROR RATE, OFTEN MEANING THE DIFFERENCE BETWEEN FACING A PENALTY AND NOT BEING SANCTIONED.

INCORPORATED IN THE HOUSE DEFICIT REDUCTION ACT, H.R. 3128, ARE PROVISIONS WHICH OFFER A COMPREHENSIVE SOLUTION TO THE PREVIOUSLY MENTIONED INEQUITIES IN THE AFDC QUALITY CONTROL SYSTEM. SEN. EVANS HAS ALSO INTRODUCED LEGISLATION TO ADDRESS STATES' CONCERNS, S.1362, WHICH IS NOW PENDING BEFORE THIS COMMITTEE. ALTHOUGH THE STATES PREFER THAT REFORM INCLUDE THE MORE COMPREHENSIVE APPROACH FOUND IN H.R. 3128, WE SUPPORT BOTH LEGISLATIVE EFFORTS TO FOCUS ATTENTION ON THIS CRITICAL ISSUE. SEN. EVANS LEGISLATION TAKES A SIGNIFICANT STEP IN ADDRESSING THE INEQUITIES WE HAVE DISCUSSED. I AM ATTACHING A SUMMARY OF THE MAJOR PROVISIONS OF S.1362 FOR YOUR FURTHER CONSIDERATION. AS I HAVE MENTIONED, SIMILAR REFORMS ARE NEEDED IN THE

MEDICAID PROGRAM, AND STATES ARE HOPEFUL THAT LEGISLATION WILL SOON BE INTRODUCED TO ADDRESS THE QUALITY CONTROL NEEDS OF MEDICAID.

FINALLY, I WOULD LIKE TO MENTION A BRIEFING BOOK THAT APWA HAS PUBLISHED ON QUALITY CONTROL IN THE AFDC, FOOD STAMPS AND MEDICAID PROGRAMS. A COPY OF THIS DOCUMENT HAS BEEN SENT TO EACH MEMBER OF THE FINANCE COMMITTEE. THE BRIEFING BOOK EXPANDS ON THE ISSUES I HAVE TOUCHED UPON TODAY AND SHOULD PROVE HELPFUL, NOT ONLY IN CLARIFYING THIS COMPLEX ISSUE, BUT IN AIDING YOU IN YOUR ATTEMPTS TO CORRECT THE DEFICIENCIES IN QUALITY CONTROL.

SOCIAL SERVICES

I WOULD LIKE TO CLOSE BY BRIEFLY ADDRESSING THE POSSIBILITY FOR SAVINGS IN SOCIAL SERVICE PROGRAMS. THE SOCIAL SERVICE PROGRAMS UNDER THE JURISDICTION OF THE FINANCE COMMITTEE PROVIDE A WIDE RANGE OF SUPPORTS AIMED AT HELPING PEOPLE RESOLVE OR COPE WITH SOCIAL PROBLEMS AND NEEDS. FROM DAY CARE TO HOMEMAKER ASSISTANCE TO SUBSTITUTE CARE, THE SERVICES AUTHORIZED BY THE SOCIAL SECURITY ACT ARE ESSENTIAL MEANS--ESPECIALLY FOR THE ECONOMICALLY DISADVANTAGED--TO REALIZE GREATER SELF-SUFFICIENCY AND WELL-BEING. AMONG THE MOST CRITICAL SOCIAL SERVICES STATES PROVIDE, WITH FEDERAL SUPPORT, ARE FOSTER CARE AND ADOPTION ASSISTANCE.

IN TESTIMONY BEFORE THIS COMMITTEE IS JUNE, WE MADE A NUMBER OF RECOMMENDATIONS FOR STRENGTHENING THE FOSTER CARE AND ADOPTION ASSISTANCE PROGRAMS THAT HAVE BEEN SHAPED DURING THE PAST FIVE YEARS BY PUBLIC LAW 96-272. THE PROVISIONS OF THIS LAW HAVE HELPED STATES TO REDUCE THE NUMBERS OF CHILDREN IN FOSTER CARE AND THEIR LENGTHS OF STAY IN CARE, AS WELL AS TO FIND PERMANENT HOMES FOR CHILDREN UNABLE TO REMAIN WITH THEIR ORIGINAL FAMILIES. THE IMPROVEMENTS WE NOW SEEK IN PUBLIC LAW 96-272 ARE DESIGNED TO

FURTHER ASSIST THE STATES IN FULFILLING THESE WORTHY AND SERIOUS GOALS.

SINCE OUR EARLIER TESTIMONY COVERS OUR PROPOSALS AND VIEWS ON THIS SUBJECT IN SOME DETAIL, I WISH TO ONLY NOTE HERE THAT MANY OF OUR RECOMMENDATIONS ARE CONSISTENT WITH THE DEFICIT REDUCTION OBJECTIVES OF THE FINANCE COMMITTEE. INCREASED EFFICIENCY IN THE OPERATION OF FOSTER CARE AND ADOPTION ASSISTANCE, AND THUS LOWER ADMINISTRATIVE COSTS, WOULD RESULT, FOR EXAMPLE, FROM OUR PROPOSALS: TO (AS I'VE ALREADY NOTED) ALLOW ALL TITLE IV-E CHILDREN (I.E., CHILDREN WHO RECEIVE EITHER FOSTER CARE MAINTENANCE OR ADOPTION ASSISTANCE) TO QUALIFY FOR MEDICAID IN THEIR STATE OF RESIDENCE; TO REPEAL THE REQUIREMENT FOR A 6-MONTH REDETERMINATION OF A CHILD'S FOSTER CARE ELIGIBILITY; AND TO DELETE THE REQUIREMENT OF A MINIMUM ADOPTION ASSISTANCE PAYMENT IN ORDER TO SECURE MEDICAID ELIGIBILITY. ADMITTEDLY, THESE RECOMMENDATIONS DO NOT HOLD THE PROMISE OF HUGE DOLLAR SAVINGS. HOWEVER, STATE ADMINISTRATORS DO BELIEVE SUCH CHANGES WILL EASE FEDERAL AND STATE COST BURDENS TO SOME EXTENT. MORE IMPORTANTLY, TOGETHER WITH THE REST OF OUR PACKAGE OF SUGGESTED IMPROVEMENTS, THEY WILL STREAMLINE AND ENHANCE THE EFFECTIVENESS OF OUR ADMINISTRATION OF FOSTER CARE AND ADOPTION ASSISTANCE. IN THIS SENSE, EVERYONE--FEDERAL AND STATE GOVERNMENTS, CHILDREN AND FAMILIES--STANDS TO GAIN. WE HOPE YOU WILL CONSIDER OUR PROPOSALS AS WORTHY CONTRBUTIONS TO THE REDUCTION OF THE NATION'S DEFICIT.

THIS CONCLUDES MY TESTIMONY. I WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

STATEMENT OF ROBERT FULTON, DIRECTOR, OKLAHOMA DEPARTMENT OF HUMAN SERVICES, STATE OF OKLAHOMA, OKLAHOMA CITY, OK

Mr. FULTON. Thank you, Mr. Chairman. I appreciate the opportunity to be here. Like Mr. Petit, I am not here to propose a bunch of money-saving actions in regard to the programs for families, children, the elderly, blind, and disabled that all of us work with.

I do want to say that I think the challenge of maintaining the present investment and making incremental improvements is one that the committee is addressing, and we are appreciative of the situation you are in relative to the financial situation.

I am speaking as a representative for myself and for the State of Oklahoma. Mr. Petit is representing our organization.

I do want to endorse the basic analysis that he has presented.

I am going to comment on several topics that are involved in matters before the committee. I hope they will be involved in actions you are dealing with as you proceed with your markup.

First, I want to comment on the question of enhanced matching for automated AFDC systems. It is very important that there be some Federal encouragement to the States for proceeding with automation in the areas of major Federal-State programs.

It can be argued that States ought to do this themselves because it makes sense in terms of getting the job done better, but there is an intense competition for resources in every State that I know of; and it isn't easy to take on a new modernization initiative that is going to last several years and cost several hundred thousand dollars to get it done.

The committee has encouraged in the past through the MMIS system, the development of automated systems in Medicaid. Those have had a substantial effect in improving States' abilities to manage those programs.

The famous system that is addressed in Senator Heinz' bill, S. 1491, is not the only route to go in terms of helping improve automation.

Indeed, while we support the notion of increased or enhanced Federal matching for the developmental costs and, indeed, we would like to see the operational phase of these systems also have enhanced matching, such as is done in the Medicaid Program.

We don't think there ought to be a mandate or timetable established by Congress that says every State has to be in FEMA's. That is a particular set of specifications. It is not necessarily needed in every State.

We would also think it reasonable, however—I would personally—to require States to pay back the enhanced match or at least the major portion of it if it undertakes the development of a system, draws enhanced matching for a considerable period, and then drops the effort.

I do think that in that situation the State reasonably could be expected to pay back that enhancement.

One problem in that regard that I want to mention, though, is that as has already been alluded by one of the witnesses, the Federal representatives who review these systems are not always the most helpful in terms of getting prompt action on questions that are presented by the State—proposals are presented—nor are they always so objective in their certification reviews that we can be guaranteed that a State just won't be dragged through the dust in trying to get a system approved.

So, there has to be some pressure on the Federal departments to do their job well and to coordinate effectively among the three major branches of the Federal Government that most of the State systems deal with: The Food Stamp Program, Medicaid Program, and the AFDC.

With regard to quality control and the question of the sanctions, I am supportive of the Evans proposal as a reasonable approach to dealing with a very serious mess in Federal-State relationships.

The conflict around quality control, the threats to programs posed by Federal fiscal sanctions is indeed a very serious matter.

There is nothing probably on the scene more destructive to effective delivery of programs than this threat to pull a couple billion dollars out of the States over the next couple years in the form of quality-control sanctions.

Error rates have come down. I believe that the error rates will come down faster if the Federal agencies maintain an aggresive posture relative to the States, hold press conferences in States that are doing a poor job on error rates, and basically embarrass the Governors.

That puts the heat on the State agencies to get the job done. The pulling away of Federal funds tends to create a situation which the State has no choice but to go to war with the Federal Government over these issues.

I want to mention a problem in SSI. We have a serious problem on the passthrough requirements in section 1618 of the SSI Program. That program is now 10 years old. The Federal Government is still propping up the State supplemental benefit rate with some requirements that we think are counterproductive.

There are some serious problems also regarding spend down of resources in the Medicaid Program. We permit spend down of income for somebody that is just over the cutoff points. We will not allow them to spend down a bank account that is a couple of hundred dollars over the cutoff point.

And so, we have serious situations of somebody having a $30,000 hospital bill, having $1,800 in the bank when they go into the hospital, and being unable to spend that $200 down to get down to the $1,600 SSI limit, even though if they were drawing income of substantial amounts and spending it all, they would be eligible.

It is a very, very bad situation, and I think it is not necessarily the intent of Congress originally, but it is the way it has been implemented.

The CHAIRMAN. I will have to ask you to conclude, Mr. Fulton.

Mr. FULTON. I am done.

The CHAIRMAN. Thank you. Mr. Ruvin.

[The prepared written statement of Mr. Fulton follows:]

TESTIMONY OF
ROBERT FULTON, DIRECTOR, OKLAHOMA DEPARTMENT OF HUMAN SERVICES
FOR SENATE FINANCE COMMITTEE
SEPTEMBER 13, 1985

Mr. Chairman and members of the Committee.

I appreciate the opportunity to appear before the Committee. While I am going to spend most of my time discussing the positive effects of enhanced Federal funding for computer systems, I do want to discuss very briefly four other issues of concern to Oklahoma.

ENHANCED FUNDING FOR COMPUTER SYSTEMS

First, I urge the Committee and the Congress to extend enhanced funding for the development and operation of computer systems utilized in the administration of AFDC programs. I commend Senator Heinz for introducing Senate Bill 1491 to do this. I want to thank Senator Boren and other members of the Committee for supporting such enhanced funding for the Medicaid program as well as in AFDC.

By way of background, let me provide the Committee with some information about Oklahoma's experience in utilizing an extensive state-wide computer system to assist administrators at all levels in the administration of public assistance programs:

Oklahoma was provided funding under the National Demonstration Program in 1969. With those funds Oklahoma established a comprehensive system that has served the Department very well over the years. The Oklahoma system maintains for all persons in AFDC cases data as would be required by Senate Bill 1491. That data is utilized as outlined below:

Social Security numbers - Data is exchanged with the following agencies utilizing the Social Security account number:

- Employment Security Commission - Compares earnings reported to our agency by recipients with earnings reported by employers to the Employment Security Commission. The system identifies at the same time any unemployment benefits paid to AFDC recipeints.

- Social Security Administration - Verifies benefits paid to AFDC recipients by the Social Security Administration under the OASDI and SSI programs.

- Inspector General's Office of HHS - compares with Federal payrolls and with assistance payments by other states.

- Selected private employers - detects recipients who have accepted jobs and failed to report change of status.

The Social Security number and name and address, as well as other data is utilized in referring recipients to other agencies for services including:

- Child Support Enforcement Unit (IV-D)

- Social Service Workers

- Vocational Rehabilitation

- Private agencies

The data is also used to assist other programs in providing services to qualified recipients.

A medical I.D. card is furnished each AFDC family. The card provides medical vendors with assurance that the recipient is eligible and that payment will be made for necessary medical care.

Data already available on the computer file is supplemented by other program - specific data to provide eligible AFDC recipients with authorization for:

- Food Stamps

- Low Income Energy Assistance

- Social Services.

Oklahoma has consistently been among those states with low error rates. Low error rates are not in my opinion, however, the greatest payoff from modern computer systems. Even bigger payoffs result from the ability to implement changes in policy as well as provide management with data that permits testing of changes in policy before implementation.

Oklahoma's system, like many systems that are in place for several years, has unfortunately become out dated. The determination was made that both the state and federal governments would gain from installation of a more comprehensive system. Availability of FAMIS funding has been critically important in making it possible for us to undertake this modernization. Oklahoma's state government has been in almost constant financial crisis for the pasts two years, and had enhanced Federal funding not been available, the needed modernization would almost certainly have been postponed and possibly cancelled entirely.

As we move ahead with updating of our system, we see many additional payoffs in the future. Among those improvements will be to provide capabilities for the employees administering AFDC to know which of the department's other programs are being utilized by each of the recipients. The system will also automatically refer through the computer system clients who can benefit from those other programs.

Oklahoma has established as a high priority, helping the AFDC recipients find employment. During State Fiscal 1984, 6,914 cases were closed as a result of jobs that the recipients obtained through our work and training programs. For the most recent twelve (12) months that number had grown to almost 8,000. We are a WIN demonstration state and are very proud of the fact that we achieved in FY 1985 a job placement rate equal to nearly 1/3 of our average caseload. That is one of the best records on AFDC job placements in the nation.

The most recent analysis of the case loads in Oklahoma shows 50% of AFDC cases receive assistance less than 12 months. Approximately 32% of the cases receive AFDC less than 6 months. Of the cases closed in Oklahoma, 43% are closed in the first 6 months. Another 24% are closed between the 7th and 12th month.

With the computer system, we identify cases most likely to benefit from the work programs and give extensive training or social services to recipients during this first year in order to reduce their dependency as well as providing work opportunities. Cases that remain on the rolls more than two years are more likely to remain on the rolls several years. It is important that individuals receive intensive help during the first months as AFDC recipients.

Utilization of a comprehensive computer system permits the coordination of various programs to assist the recipients in finding jobs; training for jobs; providing necessary medical services to eliminate medical problems that may prevent employment; and providing social services, such as day care, that will remove other restrictions to employment. Need for those services must be identified and addressed systematically to insure that individuals are provided help at the earliest possible time.

Senate Bill 1491 would mandate all states to implement the FAMIS system. I think generally, that states will react negatively to that type of mandate. It is my understanding that 43 states have already submitted and received approval of APD's (advance planning documents) to develop FAMIS systems. I believe the other states would adopt FAMIS if enhanced operational funding for the FAMIS systems were provided. These systems are not only expensive to develop, but require additional personnel and financial commitment to operate after development. Since the payoffs are not immediate and the savings are difficult to estimate precisely, state legislators are often reluctant to provide the additional budget authority to operate those systems. We know that the systems will reduce program expenditures, but since the reductions are in program dollars, it is not easy to identify the savings as being the result of implementation of the computer systems.

If a major problem is resulting from states accepting FAMIS and failing to complete the system, the Committee could consider requiring states to refund the difference between 50% and 90% funding if, after accepting enhanced funding, a state did not produce a certifiable system or abandoned the efforts.

Several other important issues within the jurisdiction of this Committee are under consideration by the Congress. I would like to comment briefly on some of those issues.

QUALITY CONTROL

Over the years Quality Control has been a source of contention between Federal and State officials. I feel that most of the problems are due to transforming a process designed to be a management improvement tool to a method of imposing penalties on the states for erroneous payments.

Senator Evans has introduced a bill (S. 1362) that I urge you favorably consider. Adoption of that bill will be a major order to what is now a chaotic situation and a real threat to maintenance of even current levels of benefits in many states. Suspending penalties until a proper study is made is absolutely essential. When legislation to address the Quality Control process is finally enacted that legislation should give consideration to the following:

(1) Elimination from the error rate computation errors that result from implementation of new legislation and new regulations imposed by the Federal Government; such requirements typically are imposed without adequate time to train staff and make the necessary changes in procedures.

(2) Elimination from the error rate computation of those errors that result from changes in circumstances after the case is certified or recertified and the recipient has not communicated new information to the worker.

(3) The inability of the Quality Control Sample to make precise determination of dollar errors. Present sampling techniques utilize the mid-point of the confidence interval. To provide equity, the lower bound of the confidence level should be used.

(4) Treatment of high error rates in a single review period when the state has had consistently low error rates for periods before and after the high error rate period.

(5) Incentive payments should be provided for performance below tolerance level if penalties are going to be assessed for error rates exceeding the tolerance.

(6) Factors governing caseloads density and caseload volumns.

SSI PASS THROUGH

Oklahoma has a serious problem with the interpretation by DHHS of legislation passed by Congress in 1983 that modified the requirements for states to maintain state supplemental payments to SSI beneficiaries.

Prior to that legislation, states had the option of continuing payments to beneficiaries of State Supplemental payments at the level in effect in December 1976, or of making payments in the aggregate to all beneficiaries at least equal to the payments made to all beneficiaries during the previous twelve months. Oklahoma thought that the change in 1983 did not modify the requirements for pass through so long as a state continued to make payments at or above the December 1976 level. We believed that the change only applied to those states meeting the requirements through the aggregate payments method. Unfortunately, the Social Security Administration has now published a notice of proposed rulemaking that will require Oklahoma to make retroactive payments to those beneficiaries who received state supplemental payments in 1984 and 1985. The state does not have the money to make those payments without curtailing other programs. The problem developed as follows:

> Legislation establishing the Federal SSI program was enacted in 1972 to be effective January 1, 1974 and requiring states to maintain payments to beneficiaries sufficient to prevent a reduction in income from the amount the state had previously been paying. The intent at that time was that states could over time phase out their payments, or at the option of the state, continue to make payments. There was no requirement on the states except to those individuals on the rolls on December 31, 1973.

A subsequent amendment required states to maintain payment levels in effect December 1976. In March 1983, the law was changed as outlined above. States can comply with the law if aggregate payments made to SSI recipients by the state equal the aggregate payments for the previous twelve months.

As you are aware, 24 states make no state payment at all to SSI beneficiaries. Of those states making payments to recipients, only three states, including Oklahoma, make payments, that, measured in constant dollars exceed the payment in effect in 1975. Oklahoma increased its payment substantially between 1976 and 1982. As a result of reduced revenue resulting from the economic downturn in 1982 and 1983, it was necessary that Oklahoma reduce its payment level in January 1984. Even after that reduction, Oklahoma's payment is 87-1/2% above the payment level in effect in December 1976.

Oklahoma should not be required to make payments increased by more than the presentage increase in Federal payments. Additionally, I would point out that a majority of these beneficiaries are aged. The aged population would prefer that we provide medical care in lieu of money. If we are required to make a retroactive payment, it is probable that the money for that will, by necessity, be diverted from our medical care program, necessitating reduced medical benefits.

SPEND DOWN OF RESOURCES

One of the Federal rules by which we are bound is that basic eligibility requirements must be met before medical payments are available on behalf of a family or an individual. The requirement that is presenting the greatest difficulty is that resources or assets of a family must be below a certain amount or the individual or family is automatically ineligible for medical benefits even when the medical bills far exceed the amount of available resources. For an individual, $1600 is the limit in liquid assets (other than a home, a car, household furnishings, clothing, and so forth) and for a couple, the limit is $2350. The Federal rules relating to the Medicaid program do not permit a "spend down" of resources or assets.

We have been advised that even one dollar over the resource limit at the time of initiation of a period of service makes the case totally ineligible. Often, the timing of the accumulation of excess resources causes the case to be identified as a Quality Control error. If the excess resource is $1, the erronous payment may be several thousand dollars for a patient with a large hospital bill. We have several instances where nursing home patients with less than $50 excess resources are found by Quality Control reviewers to be ineligible for medical payments of $1000 or more.

I feel very strongly that the Federal Government's policy on this point is shortsighted. It basically discriminates against people who have been able to accumulate modest savings or who happen to have a little cash on hand when a major medical emergency strikes.

I would recommend a change in law that would permit excess resources to be "spent down" much as excess earnings are now "spent down".

HOME AS A RESOURCE

Medicaid recipients who own homes and become ill necessitating confinement in a hospital or nursing home can retain the home so long as it is feasible for him to return home. If after the patient has been in the facility for a period of time, a determination is made that it is no longer feasible to remain in the facility, the home becomes a resource and the patient becomes ineligible immediately.

The Health Care Financing Administration has advised us that the state cannot extend eligibility, based on "bona fide effort to sell". The patient becomes immediately ineligible and often must leave the nursing home.

Mr. Chairman, that type of policy is not only wrong, it is inhuman. This problem must be solved.

For the Committee's information I am attaching statistics for the AFDC program in Oklahoma. I am sorry to say I cannot make comparisons with national statistics. The latest nation wide profile available is for fiscal year 1981. That survey was prepared by the U.S. Department of Health and Human Services with data for 1980 and 1981. Some information for 1982 was included in the summary. National data is not yet available for 1983 and 1984.

OKLAHOMA

STATE CHARACTERISTICS	FEDERAL FISCAL YEAR 1980	FEDERAL FISCAL YEAR 1981	STATE FISCAL YEAR 1985*
Average Monthly Caseload (Families	30,148	31,121	28,011
Number of Cases in Largest County	6,817	7,256	6,120
Average Monthly Number of Recipients	89,218	90,549	81,442
Percent of Population Receiving AFDC	3.0	2.9	2.5
Average Monthly Assistance Payment	$7,559,000	$7,636,000	$7,420,000
Average Monthly Payment per AFDC Family	$251	$245	$257
Maximum Payment for an AFDC Family of 3	$282	$282	$282
Number of Applications Received Annually	39,612	37,043	41,630
Number of Applications Approved Annually	19,654	18,770	27,549
Number of AFDC Hearings Requested Annually	645	340	587
Unemployment Rate	4.8	3.6	7.3 (June 1985)
Per Capita Income	$9,066	$10,602	$11,182*

Type of Administration	State Administered
Program Options	Children 18-21 in School Emergency Assistance

* 1983 Per Capita Income (National $11,675).
Source: USDC/BC, State Govt. Tax Collections.
Measures p/c personal income.

STATEMENT OF THE HONORABLE HARVEY RUVIN, COMMISSIONER, DADE COUNTY, FL; AND SECOND VICE PRESIDENT, NATIONAL ASSOCIATION OF COUNTIES

Commissioner RUVIN. Mr. Chairman, my name is Harvey Ruvin, and I am privileged to serve as a county commissioner in Dade County, FL, and also the second vice president of the National Association of Counties. In our system, that is president-elect twice removed.

It certainly is not an understatement to say that this Finance Committee has a major say, perhaps even a determinative say, in the financial future of county government.

Under your jurisdiction in this hearing are three of the most important and costly program issues facing local government: general revenue sharing, Medicaid, and Social Security Medicare coverage of State and local government employees.

It certainly is commendable that with a $200 billion deficit, both Congress and the administration are attempting to face up to reducing that deficit.

However, we are alarmed that the first budget resolution takes a disproportionate share from the State and local governmental programs.

Gentlemen, since the late 1970's, the National Association of Counties has supported cuts in certain federally assisted programs. In that process, we have already absorbed, accepted some $40 billion of cuts since 1981 in domestic assistance.

Even so, we recognize the need for each level of government to share the burden that you are attempting to face here today.

However, with this retrenchment in domestic assistance, coupled with the fact that in 39 States in this Nation, local governments are facing property tax limitations from either constitutional provisions or through referendums, our main ability to raise money for our programs has been extremely curtailed, and most of these local governments are almost up to those limits at this point.

We think that this whole package is creating what is referred to as a social deficit. I can also refer to it in that way, but I think I can call it also a human deficit that is increasing perhaps at a much more rapid rate than the financial deficit that we are attempting to deal with here today.

And it is one that we are going to have to pay for—if not now, later. Back home right now I am in the middle of our budgetary process, and last Tuesday we—the county commissioner of Dade County—sat through 7½ hours of hearings, 125 speakers, hearing about these needs, knowing that our ability to really deal effectively with them is extremely curtailed and faces even more of a curtailment in coming years with the impending, we hope soon-to-be-dealt-with problem of general revenue sharing next year.

According to the just-released Annual Report of the Office of Revenue Sharing, revenue sharing is the only form of Federal assistance received by more than 30,000 local governments.

We appreciate the fact that the budget resolution assumes full funding of the program for fiscal year 1986 at $4.6 billion.

Our members have been sitting on the edge of their chairs awaiting the results of the protracted budgetary process; and what we have been told all along is that we may get through this year, but next year we are going to be facing a total elimination of general revenue sharing.

And I think it is not too early to start arguing that case here today. Full budget funding for fiscal year 1986 was good news for county governments, and we hope that the Finance Committee will stay with that budget resolution—that aspect of the budget resolution passed by the Senate.

Elimination of GRS after fiscal year 1986 would be a disaster for counties. The rationale for the establishment of GRS still exists, while the needs that they were designed to meet have increased.

GRS was meant to be tax-based sharing, an attempt to allow local government to share in the broader tax base and taxing authority of the Federal Government in order to assume the cost of national policy objectives and mandates.

It is the most cost effective and the least in administrative costs.

National goals, standards, mandates, and requirements have, in fact, proliferated in the last 13 years since GRS was established.

Now Congress is telling local government that most of the money provided to meet these mandates will be gone next year. We, however, must remain in compliance with these mandates or be fined.

GRS helps communities which need the dollars the most. Sixty-six percent of GRS funds go to the communities below the median income level. The less needy communities do receive proportionally less GRS, but their residents are taxpayers also.

However, there are those who believe the program formula should be reevaluated. Therefore, let us go through the reauthorization process rather than eliminate the program simply because $4.6 billion per year is such a tempting target.

I note that the red light is on, Mr. Chairman.

My comments address the Social Security and Medicare coverage problem, as well as the Medicaid and Medicare problem, the assumptions of the budget resolution and the drain on local dollars that this, again, will mean.

I want to accent in conclusion that with the last 5 years of domestic retrenchment in dollars from the Federal Government with the backdrop of all of the tax limitations, we in local government are strapped. And in this whole debate about doing something about the financial deficit that we——

The CHAIRMAN. I ask you to conclude, Mr. Ruvin.

Mr. RUVIN. We have to keep in mind that this is a human deficit that we are going to have to pay some day. And our ability to pay it is so constrictive that we must continue to look for help, particularly GRS.

Thank you very much. I'll be happy to answer any questions.

The Chairman. Thank you, sir.

[The prepared written statement of Mr. Ruvin follows:]

NATIONAL
ASSOCIATION
of
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STATEMENT OF

THE HONORABLE HARVEY RUVIN, COMMISSIONER
DADE COUNTY, FLORIDA
AND
SECOND VICE PRESIDENT
OF THE NATIONAL ASSOCIATION OF COUNTIES

BEFORE THE
FINANCE COMMITTEE
UNITED STATES SENATE

ON BEHALF OF

THE NATIONAL ASSOCIATION OF COUNTIES

SEPTEMBER 13, 1985

WASHINGTON, D.C.

STATEMENT OF THE HONORABLE HARVEY RUVIN, COMMISSIONER, DADE COUNTY, FLORIDA AND SECOND VICE PRESIDENT OF THE NATIONAL ASSOCIATION OF COUNTIES, BEFORE THE FINANCE COMMITTEE, UNITED STATES SENATE.

MR. CHAIRMAN,

MY NAME IS HARVEY RUVIN. I AM PRIVILEGED TO SERVE AS A COMMISSIONER IN DADE COUNTY, FLORIDA AND AS THE SECOND VICE-PRESIDENT OF THE NATIONAL ASSOCIATION OF COUNTIES.* I APPRECIATE THE OPPORTUNITY TO TESTIFY TODAY BEFORE THE FINANCE COMMITTEE IN CONNNECTION WITH THE BUDGET RESOLUTION DEFICIT REDUCTION REQUIREMENT.

IT IS NOT AN UNDERSTATEMENT TO SAY THAT THE FINANCE COMMITTEE HAS A MAJOR SAY IN THE FINANCIAL FUTURE OF COUNTY GOVERNMENT. UNDER YOUR JURISDICTION IN THIS HEARING ARE THREE OF THE FOUR MOST IMPORTANT AND COSTLY ISSUES FACING LOCAL GOVERNMENT: GENERAL REVENUE SHARING, MEDICAID, AND SOCIAL SECURITY/MEDICARE COVERAGE OF STATE AND LOCAL GOVERNMENT EMPLOYEES. ONLY THROUGH THE INTERVENTION OF THE SUPREME COURT IN THE GARCIA V. SAN ANTONIO CASE, IS THE LABOR AND HUMAN RESOURCES COMMITTEE IN THE ENVIABLE POSITION OF BEING ABLE TO SAVE LOCAL GOVERNMENT $1-3 BILLION IN OVERTIME PAY.

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* THE NATIONAL ASSOCIATION OF COUNTIES IS THE ONLY NATIONAL ORGANIZATION REPRESENTING COUNTY GOVERNMENT IN THE UNITED STATES. THROUGH ITS MEMBERSHIP, URBAN, SUBURBAN AND RURAL COUNTIES JOIN TOGETHER TO BUILD EFFECTIVE, RESPONSIVE COUNTY GOVERNMENT. THE GOALS OF THE ORGANIZATION ARE TO: IMPROVE COUNTY GOVERNMENT; SERVE AS THE NATIONAL SPOKESMAN FOR COUNTY GOVERNMENT; ACT AS A LIAISON BETWEEN THE NATION'S COUNTIES AND OTHER LEVELS OF GOVERNMENT; ACHIEVE PUBLIC UNDERSTANDING OF THE ROLE OF COUNTIES IN THE FEDERAL SYSTEM.

IT IS CLEAR THAT WITH A $200 BILLION DEFICIT, CONGRESS AND THE ADMINISTRATION MUST FACE UP TO REDUCING THE DEFICIT. LOCAL GOVERNMENT HAS FOR THE MOST PART MET THE CHALLENGE TO KEEP SPENDING UNDER CONTROL. IN DADE COUNTY WE ARE REQUIRED TO OPERATE WITH A BALANCED BUDGET. HOWEVER, WE ARE VERY CONCERNED THAT OUR BUDGETS WILL BE UNBALANCED BY A UNILATERAL WITHDRAWAL OF THE FEDERAL GOVERNMENT FROM THE INTERGOVERNMENTAL FINANCIAL SYSTEM COUPLED WITH THE IMPOSITION AND CONTINUATION OF VERY EXPENSIVE MANDATES. WE ARE ALARMED THAT THE FIRST BUDGET RESOLUTION TAKES A DISPROPORTIONATE SHARE FROM STATE AND LOCAL GOVERNMENT PROGRAMS.

MR. CHAIRMAN, WE ALL WORK FOR THE SAME VOTERS AND TAXPAYERS. THE FUNDS WE RECEIVE FROM THE FEDERAL GOVERNMENT ARE DOLLARS OUR CITIZENS PAY IN FEDERAL INCOME TAX. WE MUST CONTINUE TO SHARE THE BURDEN BETWEEN US. THIS, HOWEVER, DOES NOT MEAN THAT COUNTIES ARE TURNING AWAY FROM THE NEED TO REDUCE THE FEDERAL DEFICIT.

SINCE THE LATE 1970'S, THE NATIONAL ASSOCIATION OF COUNTIES SUPPORTED CUTS IN CERTAIN FEDERAL DOMESTIC ASSISTANCE PROGRAMS. IN THAT PROCESS WE HAVE ALREADY ACCEPTED $40 BILLION OF CUTS SINCE 1981 IN DOMESTIC ASSISTANCE. EVEN SO, WE RECOGNIZE THE NEED FOR EACH LEVEL OF GOVERNMENT TO SHARE THE BURDEN. DURING THE BUDGET DEBATE WE HAVE SUPPORTED AN ACROSS-THE-BOARD FREEZE FOR THE FISCAL YEAR 1986, WITH THE EXCEPTION OF MEANS-TESTED ENTITLEMENT PROGRAMS WHICH SERVE THE POOR, THE SICK, AND THE LOW INCOME ELDERLY.

WE REALIZE THAT A FREEZE ALONE WILL NOT ENABLE THE CONGRESS TO MEET ITS DEFICIT REDUCTION GOALS. THAT IS WHY WE ARE HERE TODAY

TO GIVE YOU AN IDEA WHERE WE FEEL WE CAN SACRIFICE AND WHERE WE CANNOT.

GENERAL REVENUE SHARING

OVER 39,000 UNITS OF GOVERNMENT ARE ELIGIBLE FOR GENERAL REVENUE SHARING, INCLUDING 3049 COUNTIES. ACCORDING TO THE JUST RELEASED FISCAL YEAR 1984 ANNUAL REPORT OF THE OFFICE OF REVENUE SHARING,"...JURISDICTIONS WITH POPULATION UNDER 10,000, MOST OF WHICH RECEIVE NO OTHER ASSISTANCE FROM THE FEDERAL GOVERNMENT, MAKEUP MORE THAN 85 PERCENT OF THE PROGRAM'S RECIPIENTS. REVENUE SHARING IS THE ONLY FORM OF FEDERAL ASSISTANCE RECEIVED BY MORE THAN 30,000 LOCAL GOVERNMENTS." APPROXIMATELY 24 PERCENT OF OUR COUNTIES FALL INTO THAT CATEGORY.

WE APPRECIATE THE FACT THAT THE BUDGET RESOLUTION ASSUMES FULL FUNDING OF THE PROGRAM FOR FISCAL YEAR 1986 AT $4.6 BILLION. OUR MEMBERS HAVE BEEN SITTING ON THE EDGE OF THEIR CHAIRS AWAITING THE RESULTS OF THE PROTRACTED BUDGET PROCESS. NACO STAFF HAS ANSWERED HUNDREDS OF CALLS FROM COUNTY EXECUTIVES, COMMISSIONERS, BUDGET AND PROGRAM PERSONNEL ABOUT WHAT THEY CAN EXPECT FROM THE FEDERAL GOVERNMENT IN TERMS OF GRS FOR FISCAL YEAR 1986 AND THE OUT YEARS. FULL BUDGET FUNDING FOR FISCAL YEAR 1986 WAS GOOD NEWS FOR COUNTY GOVERNMENTS AND WE HOPE THE FINANCE COMMITTEE WILL STAY WITH THE BUDGET RESOLUTION PASSED BY THE SENATE.

ELIMINATION OF GRS AFTER FISCAL YEAR 1986 WOULD BE A DISASTER FOR COUNTIES. THE RATIONALE FOR THE ESTABLISHMENT OF GRS STILL EXISTS, WHILE THE NEEDS HAVE INCREASED. GRS WAS MEANT TO BE TAX BASE SHARING--AN ATTEMPT TO ALLOW LOCAL GOVERNMENT TO SHARE IN THE

BROADER TAX BASE AND TAXING AUTHORITY OF FEDERAL GOVERNMENT IN ORDER TO ASSUME THE COST OF NATIONAL POLICY OBJECTIVES AND MANDATES. IT IS A COST-EFFECTIVE PROGRAM, WITH MINIMAL ADMINISTRATIVE COSTS.

NATIONAL GOALS, STANDARDS, MANDATES, AND REQUIREMENTS HAVE PROLIFERATED IN THE 13 YEARS SINCE GRS WAS ESTABLISHED. THE CONGRESS HAS PROPERLY DIRECTED LOCAL GOVERNMENT TO KEEP THE ENVIRONMENT CLEAN BY BUILDING WASTEWATER TREATMENT PLANTS, RESOURCE RECOVERY FACILITIES AND NEW AND IMPROVED LANDFILLS. NOW CONGRESS TELLS LOCAL GOVERNMENT THAT MOST OF THE MONEY TO UNDERTAKE THESE PROJECTS WILL BE GONE IN A YEAR. WE, HOWEVER, MUST REMAIN IN COMPLIANCE WITH THESE MANDATES OR BE FINED. COUNTY JAILS HOUSE SEVEN MILLION PRISONERS EACH YEAR AND COURTS, ACTING UNDER FEDERAL STATUTES, TELL US TO SPEND MONEY TO EXPAND AND IMPROVE OUR FACILITIES. WELL, WE NEED GRS TO HELP FUND JAILS THAT COST $50,000 PER CELL TO CONSTRUCT, AMONG OTHER RESPONSIBILITIES.

POOR PEOPLE CONTINUE TO NEED SERVICES AND WHILE THE FEDERAL COMMITMENT TO THE DISADVANTAGED HAS DECREASED, THE NEEDS, HOWEVER, HAVE NOT AND LOCAL GOVERNMENT MUST STILL RESPOND. GRS HAS PROVIDED US WITH A FLEXIBLE REVENUE SOURCE TO FILL THE GAP LEFT BY THE FEDERAL RETRENCHMENT.

GRS FUNNELS FUNDS TO COMMUNITIES WHICH NEED THE DOLLARS THE MOST. SIXTY-SIX PERCENT OF GRS FUNDS GO TO COMMUNITIES BELOW THE MEDIAN INCOME. OTHER LESS NEEDY COMMUNITIES DO RECEIVE PROPORTIONATELY LESS GRS, BUT THEIR RESIDENTS ARE ALSO TAXPAYERS.

HOWEVER, THERE ARE THOSE WHO BELIEVE THE PROGRAM FORMULA SHOULD BE EVALUATED. THEREFORE, LET US GO THROUGH THE REAUTHORIZATION PROCESS RATHER THAN ELIMINATE THE PROGRAM SIMPLY BECAUSE $4.6 BILLION PER YEAR IS SUCH A TEMPTING TARGET.

SOCIAL SECURITY AND MEDICARE COVERAGE

THE BUDGET RESOLUTION ASSUMES COVERAGE UNDER SOCIAL SECURITY OF ALL NEWLY HIRED STATE AND LOCAL GOVERNMENT EMPLOYEES AND COVERAGE UNDER MEDICARE OF ALL PRESENT AND FUTURE STATE AND LOCAL GOVERNMENT EMPLOYEES. THOSE CHANGES IN THE SOCIAL SECURITY ACT WILL COST STATE AND LOCAL GOVERNMENT $8.4 BILLION OVER THE NEXT THREE YEARS.

NACO POLICY SUPPORTS THE PRESENT OPTIONAL INCLUSION OF STATE AND LOCAL EMPLOYEES IN THE SOCIAL SECURITY SYSTEM. HOWEVER, IF CONGRESS DECIDES OUR EMPLOYEES ARE TO BE COVERED, WE ASK THE COMMITTEE TO GIVE SERIOUS CONSIDERATION TO SEVERAL PROBLEM AREAS. OUR MAJOR AREA OF CONCERN WOULD BE THE POSSIBLE INCLUSION OF ALL EMPLOYEES UNDER MEDICARE. WE URGE MEDICARE COVERAGE FOR ONLY NEW EMPLOYEES OF STATE AND LOCAL GOVERNMENTS. TO MAKE LOCAL GOVERNMENTS START PAYING INTO A SYSTEM OF MEDICAL CARE COVERING ELDERLY PERSONS WHEN MANY COUNTIES ALREADY HAVE SUCH A PROGRAM IN PLACE WOULD BE EXPENSIVE AND DUPLICATIVE. IT MAKES MUCH MORE SENSE TO COVER NEW EMPLOYEES WHO HAVE NOT BEEN PART OF THE ONGOING SYSTEM AND WHOSE BENEFIT PACKAGE COULD BE ADJUSTED TO ACCOMMODATE MEDICARE COVERAGE. FORCING CURRENT EMPLOYEES INTO THE MEDICARE SYSTEM WOULD BE DISRUPTIVE TO COUNTIES' PRESENT HEALTH CARE

PROGRAMS, WHICH ARE OFTEN THE RESULT OF COLLECTIVE BARGAINING AGREEMENTS.

OUR SECOND AREA OF CONCERN REGARDING SOCIAL SECURITY AND MEDICARE COVERAGE FOR LOCAL GOVERNMENT EMPLOYEES IS THE COST TO COUNTY GOVERNMENTS OF SETTING UP THIS NEW SYSTEM AND MAINTAINING, FOR MANY COUNTIES, WHAT WILL BE A DUAL RETIREMENT PROGRAM. THESE NEW ADMINISTRATIVE COSTS, YET ANOTHER FEDERAL MANDATE, SHOULD BE ABSORBED BY THE FEDERAL GOVERNMENT. IN ADDITION, THERE SHOULD BE NO FEDERAL RESTRICTIONS ON THE MAINTENANCE OR INITIATION OF SEPARATE SUPPLEMENTARY RETIREMENT, HEALTH, OR DISABILITY SYSTEMS. FINALLY, THE JANUARY 1, 1986 DEADLINE FOR EFFECTING THIS ADDITIONAL SOCIAL SECURITY AND MEDICARE COVERAGE IS MUCH TOO SOON. WE WOULD ADVOCATE A TRANSITION PERIOD OF NO EARLIER THAN JANUARY 1, 1987 TO IMPLEMENT THIS PROGRAM.

MEDICAID AND MEDICARE

AS PROVIDERS AND FINANCERS OF LAST RESORT FOR THE POOR, COUNTY GOVERNMENTS HAVE MAJOR HEALTH CARE RESPONSIBILITIES AT THE LOCAL LEVEL. THE GROWTH OF THE UNINSURED POPULATION, RISING HEALTH CARE COSTS AND PROGRAM REDUCTIONS, HAVE CONTRIBUTED TO A CRITICAL PUBLIC HEALTH CARE SITUATION. COUNTIES FUND BILLIONS OF DOLLARS OF THIS CARE BUT CANNOT PROVIDE ADEQUATE SERVICES WITHOUT SUBSTANTIAL SUPPORT FROM THE FEDERAL LEVEL. THEREFORE, NACO HAS LONG OPPOSED ANY REDUCTIONS IN THE FEDERAL MEDICAID PROGRAM. IF THE COMMITTEE ACCEPTS THE CONFERENCE AGREEMENT OF $450 MILLION IN REDUCTIONS OVER THREE YEARS TO COME FROM THIRD PARTY INSURERS, WE STRONGLY SUPPORT LANGUAGE SPECIFYING THAT COLLECTION EFFORTS NOT

ADVERSELY AFFECT BENEFICIARIES, OR THAT SUBSEQUENT COSTS NOT BE PASSED ON TO LOCAL GOVERNMENTS.

WE UNDERSTAND THAT THE CONCERN REGARDING THE FINANCING OF THE MEDICARE TRUST FUND IS THE REASON FOR THE $13 BILLION IN PENDING REDUCTIONS. HOWEVER, WE CALL ON THIS COMMITTEE TO PROTECT THOSE PUBLIC HEALTH FACILITIES THAT SERVE A DISPROPORTIONATE SHARE OF THE POOR WITH LANGUAGE SIMILAR TO THE HOUSE WAYS AND MEANS COMMITTEE.

MR. CHAIRMAN, THIS CONCLUDES MY TESTIMONY. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS THE COMMITTEE MAY HAVE.

The CHAIRMAN. Ms. Matula, you argue for making home and community base services a State option. I'm not sure I'm fully prepared to agree yet, but, I am moving in that direction.

However, I know how frightened the administration is of a new entitlement program. That's what they think it is. It is just going to go willy-nilly.

What kind of cost containment do you suggest? Just a lid from the Federal Government that says here is *x* amount of money, that's all you will receive? Or do you have some other suggestions?

Ms. MATULA. No; I think we can follow a reasonable course of holding costs down, but without putting an artificial lid on it to begin with.

The CHAIRMAN. What are your suggestions for holding them down?

Ms. MATULA. We do not know, for example, how to estimate properly the numbers of persons in need of this service.

The CHAIRMAN. That's exactly what the administration is afraid of.

Ms. MATULA. Well, we could begin——

The CHAIRMAN. There are all kinds of people out there in need of this service who at the moment are getting no service.

Ms. MATULA. I think anyone would agree, though, that from this year, 2 or 3 years down the road, the number will not grow smaller. I think that's a safe assumption. The number of people in need will not be less tomorrow than it is today.

The CHAIRMAN. If that is true, and we don't have a lid, how much——

Ms. MATULA. Our waiver limits us to those. We are really limited today unless we build more nursing home beds.

The CHAIRMAN. How do we know how much it is going to cost, then?

Ms. MATULA. Well, we can keep the cost per person very tightly controlled to less than the cost of institutional care.

The CHAIRMAN. Oh, I understand that. How do we know how many people?

Ms. MATULA. We can make certain that the people who are eligible for the program are the same people who would require nursing home care. We are not going to give it to just anyone who demands it. It would really be on a need base, a very careful needs assessment. So that we would know, given ordinary circumstances, we would be paying more for these folks in institutional care.

The CHAIRMAN. But would the needs assessment be that these would be people who would otherwise be eligible to be institutionalized?

Ms. MATULA. Precisely.

The CHAIRMAN. OK.

Ms. MATULA. So we have no interest in opening the lid on this because we are paying our share of the cost. We just feel we can't be limited to just those in a nursing home bed today.

The CHAIRMAN. Assuming we don't go to a State option of some kind, how can we speed up the waiver process?

Ms. MATULA. Well, certainly we could limit the tricks that we play with the 90-day call. Questions should logically be asked by the 60th day. There is no reason to wait until the end to ask for clarifying information.

And then it shouldn't be turned back to another 90-day clock. I think a reasonable 30 days to react to the responses is certainly adequate.

The CHAIRMAN. You mean statutorily say they have got 30 days to answer?

Ms. MATULA. That's right. Or you could just say overall, 120 days.

The CHAIRMAN. Well, of course, then you know what happens. They answer "No."

Ms. MATULA. Yes. [Laughter.]

But what I am saying is it could be made simple. They know that. In good faith, they could actually do that.

The CHAIRMAN. Do you think they really delay this because they don't like the whole program anyway and they would just as soon not have any waivers?

Ms. MATULA. I think initially the delays were caused because more than one department was calling the shots. And I think there were internal delays.

Certainly now with some experience, their track record should be speeded up, though I have not examined closely how that has been in recent months. They've turned my request for renewal down, so I'm busy fighting my own battles right now.

The CHAIRMAN. I was half serious when I said you want to be careful about 30 days. I've been in this business long enough that sometimes I don't want to get answers too hastily because I get the wrong answers. And if I lay the groundwork properly and take a little longer, I get the right answer.

Ms. MATULA. You could limit the number of times they come back to the well. You could say that clarification should be limited to two times. That holds it down somewhat.

The CHAIRMAN. Because I don't know what happens, though, when they ultimately say "No."

Ms. MATULA. Well, if they are going to say "No," we would rather know sooner than later, given the investment of time and energy that the local governments and the State governments are putting into this now.

Mr. PETIT. Senator Packwood, when they say "No" what we do is—I control the certificate of need program in our State—and we just simply authorize construction of more nursing home beds and we bill the Federal Government for 70 percent of the cost.

The CHAIRMAN. Let me ask you, Mr. Petit, the same question I asked Governor Castle. From the Federal Government's standpoint, we seem to think the quality-control system has worked. We have seen the error rate go down and down. And we question why should we not continue a system which to us seems to have worked. What's your response?

Mr. PETIT. When I took office in 1979, our error rates ranged as high as 18 percent. Today, they are typically around 3 percent. We have doubled our administrative costs during that period. And at this point, as I think Mr. Fulton stated, the approach that the Federal Government is taking is putting us strictly on the defensive.

And what we are doing is charging up our lawyers to do battle with the Federal Government in the courts. We are before our legislative bodies on a regular basis asking for additional administrative costs.

The most important thing is to take on Senator Evans' bill and Representative Matsui's bill and take a look at this whole quality-control program and make it a more streamlined and efficient process.

The States are highly motivated to control their errors. What we have done in Maine in the last few years is to take the savings that we have realized from implementing third-party liability laws, reducing our error rates, child support enforce payments, and put them into increased Medicaid benefits and increased AFDC benefits. AFDC benefit increases have averaged about 7 percent over the last 6 years. We have done it by tightening up on our system.

That's how we have had to endure cuts and a slowed down economy over the last 5 or 6 years. But at this point, the role is an antagonistic and adversarial one between the Federal Government and us.

The CHAIRMAN. Senator Long.

Senator LONG. I'll yield to Senator Boren at this time.

Senator BOREN. I thank you, Senator Long, for yielding to me. They have called me to come to the Agriculture Committee to present an amendment. We are in session.

I'm glad to have the director of the State Department of Human Services from Oklahoma, Mr. Fulton, here this morning. He has wide experience with HEW and the Social Security Administration and also Senator Bellman on the Budget Committee as well.

You mentioned this problem of the SSI pass along during your comments. And I understand from what you have said that States like Oklahoma and perhaps others are being treated unfairly under section 1618 regarding State supplements to Federal SSI benefits because you raised the benefits higher than was required by Federal law and now you are penalized by that as some States have gone through a reversal of economic circumstances.

How does that exactly work?

Mr. FULTON. Well, Senator Boren, the 1983 amendments required apparently—we thought there was some ambiguity about the wording of them, but it had been interpreted by both HHS and the GAO to require that you maintain the higher of the 1976 or the 1983 levels.

What happened to us is that we got into a tremendous financial crisis. We took a risk on that interpretation of the law, and we actually reduced our benefits in January 1984 by $9 a month.

The Federal Government—the HHS has now served notice on us that we have until the end of calendar year 1985 to pay back, in effect, everything that would have been paid in 1984. So we are facing a necessity to pay out $4 or $5 million even though over the period since the SSI Program began Oklahoma's benefit rate, even at the current level, has increased faster than the Federal benefit has increased in percentage terms.

And, indeed, we are among the higher States in terms of paying an SSI supplement. So it just seems strange that the Federal Government would prop us up in detail on a benefit level that we think would require money to be spent now that we could better use in prescription drugs and some other things that are important to the elderly.

Senator BOREN. This will actually hurt other programs. We've been paying more than the Federal Government required and now we are being penalized because we have had to drop back, but we are still above the minimum level.

Mr. FULTON. Right. Oh, yes.

Senator BOREN. And if this happens, we will be penalizing other programs.

Mr. FULTON. That's right. The way we would get that money is to squeeze somewhere else because we are not in a surplus situation.

Senator BOREN. Would we further reduce our payments to the elderly, blind, disabled, if the change you are proposing is made?

Mr. FULTON. No, sir. We had a Governor's commission that recommended that we phaseout the State supplement in Oklahoma. Neither myself, the commissioner for human services, which is my governing board, nor Governor Nye support that. We want to maintain the benefit level where it is now.

But we don't think we should be forced to go back and make a catchup payment.

Senator BOREN. Right. I understand.

Let me ask quickly about one other point you raised that seems astounding to me and that is this situation where if someone has some money in the bank, say $1,000 in the bank, and they are just a little bit over, $200 or $300 over the income level to qualify and they are facing a $15,000 medical bill, as I understand, you said that if their income was a little bit too high, they can spend that income down and then quality for help.

Mr. FULTON. That's right.

Senator BOREN. But if this is in the bank, they cannot then do that. They have this as an asset. So that they might be just $200 over facing a $15,000 bill, and yet they are totally disqualified of any help. Is that correct?

Mr. FULTON. Yes, sir. Your numbers are a little off, but the basic situation is exactly as you describe it. The Federal interpretation of the current Social Security medically needy provision is that you may spend down income but may not spend down assets or resources. The SSI eligibility limit on resources, liquid resources, for a single individual living alone is $1,600.

Senator BOREN. Right.

Mr. FULTON. If somebody has got $2,000 that they have managed to accumulate in the bank, and they have that on the day they enter into a hospital or some other service, they are ineligible for the entire amount of the service, regardless of how big that bill is.

Senator BOREN. Thank you very much.

Thank you, Senator Long, for letting me go ahead. I have got to go back and handle a program dear to you and that's the work requirement for food stamps.

Senator LONG. I will address myself to Mr. Fulton.

You and others have made some very good points, and I'll take note of what you said about the spend-down problem. I would like to help on that, if I can.

Let me tell you the thing that concerns me, and I think it concerns others. We need to get the best results we can from the money we can make available, just as you do.

I think I speak for the majority of this committee, and I think the majority in Congress, when I say that we would like you to have more latitude to run a program for the good of your people. But we look out there and sometimes we just don't think that the administrators—I don't say all, there are a lot of exceptions to what I am going to say—as a group can really measure up in having made the best use of the money they have.

Let's just look at child support. You know, for years we had people telling us that there is no potential for raising money there. I don't believe you were one of them, and I don't think your predecessor was one of them. But they were telling us that there is no potential; you aren't going to raise any money by pursuing those fathers. But in fact we have raised a lot of money, about $1 billion a year, I believe by making fathers help their children. Not just children on welfare, but ones who otherwise would be potential welfare clients, if we didn't get them their support payments.

There is a tremendous potential there. And if I do say so, could do a better job on child support enforcement to make those fathers help support those children.

Now some of us, and I am one of them, would like to give the welfare directors—you and others—the latitude to take money that we are putting into AFDC and into food stamps and use that money to help people get jobs. It has got to be cheaper to subsidize an able-bodied person into some kind of employment than it is to just pay that person to live on a welfare check. And it has got to be better for society and for that person.

Some of the best information I get is from welfare case workers. One of them told me about a situation where they had some success in getting the Government to employ someone in a government installation who otherwise would be living on the welfare rolls.

This same person went on to tell me something that I know to be true—that when you call upon the Government to employ some of these people, well, you are overlooking the big potential. The big potential is out there in private enterprise.

If we take all that money we have available for food stamps and all that money we have available here for cash payments and we use a lot of that to subsidize those people into the employment in private industry, it would reduce the rolls; you would benefit the people; and in the long run you would save money on the program.

Now why can't you get together with the other welfare directors and come in here and advocate some of this? I gain the impression sometimes that the average welfare director is very much interested in keeping his clientele.

Not you, Mr. Fulton. I'm not talking about you. Oklahoma has got a pretty good record in that regard.

But I do feel that if you look at the record of the average welfare director, you wonder whether he isn't more interested in maintaining his clientele than he is in trying to get people off the rolls.

And I'm not saying we should put them off into poverty. I'm talking about moving them out of dependency into employment.

Now what can you tell us, if anything, that would give us some hope that if we will support you, you can get something done?

Mr. FULTON. Senator Long, first, let me say that I agree with you about the importance of trying to help people get independent instead of prolonging or promoting dependence. There is nothing more crucial in terms of administering these programs than to make sure they aren't viewed as long-term support mechanisms for the majority of the recipients.

There are going to be some that are going to stay on the caseload a long time regardless of how good we are. But I believe that there has been a transition, a transformation, and it's still underway, regarding the way the leadership of the State human services agencies see their job in regard to these clients.

We are stressing work. We are stressing the child support. We are stressing low errors, good management in these programs.

And as Mr. Petit said, we are making headway with regard to bringing the errors down. We have in Oklahoma a program of work search, job placement. We use the work fare option as part 1 of our tools. It's several hundred any one time in our State that are on work fare assignments. It's very useful. It's not the whole solution.

But we are placing now in Oklahoma, close to one-third of the average caseload per year in jobs with our own efforts. And more and more States are excited about that.

Now, Senator Long, if I could just reflect a little bit. One of the problems that I think really has caused this, perhaps as you see it, lack of focus on the work question was the way the WIN Program operated. With the welfare staff basically being told this isn't your job, you hand them over to the employment service, now what is happening with the WIN demos that you have authorized back in 1981 is that the work part of the needs of the welfare recipient is coming back into the human services agency in a very big way.

And we tell our case workers, your job is the whole need of the person and work opportunity and helping somebody to get ready for a job. That is a critical part of that. And I think that is happening much more throughout the country.

Senator LONG. Thank you.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you very much, Mr. Chairman.

Mr. Censoni and Ms. Matula, I would like to talk about the life safety code of 1985. As I understand the situation, currently small community-based facilities must meet safety codes that are applicable to far larger facilities. There is in existence a life safety code of 1985 which has been approved and adopted by the National Fire Protection Association—so there is no question of danger or risk involved here—that would permit the approval of the smaller facilities without all of the costs that are currently being imposed upon them by HCFA.

Could you give me some thoughts on that, Mr. Censoni?

Mr. CENSONI. You are correct in the statements about the 1985 life safety code. HCFA currently has two processes going on that would, in fact, put that life safety code in place.

Those processes, in one case, have been going on, I believe, for almost 2 years. I can't remember exactly, but it has been a very long time. And we fear that that is going to continue for a very long time.

In the meantime, we are spending extraordinary amounts of money in building small group homes for no particularly good reason except that to get them qualified, they must meet the old life safety code. When the new life safety code passes, those dollars will be reimbursed to us by the Federal Medicaid system.

And, again, we don't see much logic in waiting any longer.

Senator CHAFEE. In other words, what you are doing is building facilities that meet a higher standard than really is necessary; is that right?

Mr. CENSONI. That is correct.

Senator CHAFEE. So everybody loses.

What do you say to that, Ms. Matula?

Ms. MATULA. I agree, but it is not a State option to ignore the Federal requirements.

Senator CHAFEE. I hope, in connection with this reconciliation, that we can mandate that.

Second, what about the extension of the renewal period? It is currently 3 years. I have some thoughts that it should be extended to 5. What are your thoughts on that?

Ms. MATULA. I think that's excellent. As it is now, it takes us so long to get approval that sometimes we have to scramble to get our programs in place. And before you know it, the time is coming up where we have to prepare the documentation for renewal. And we are spending far too much time on that process and not on the program. Five years would be great.

Senator CHAFEE. Now many people think that the idea of a small home not meeting the ICFMR standards means a lower quality of care or safety. Would either of you comment on that?

Mr. CENSONI. Well, just to say——

Senator CHAFEE. It kind of touches on the previous question.

Mr. CENSONI. In our experience, in fact, integrating people into the community by making the houses smaller, we can afford to—

we don't have to do all these other things like 8-foot hallways and sprinklers, et cetera. We think not only are the costs lower, the services are better, and we feel quite good that the people are very safe.

Again, we are directly responsible for assuring the safety of individuals in these homes. We are not going to do anything that endangers them.

Senator CHAFEE. Ms. Matula, same?

Ms. MATULA. Yes.

Senator CHAFEE. All right. Now another question. One of the issues that we are thinking about during the reconciliation is some method of fixing up this waiver program. And as I mentioned, I have a couple of proposals on this. But my question is this: Are simple adjustments to this program enough? Don't we really need a total reform of the Medicaid Program as it applies to the disabled?

Ms. MATULA. Both to the developmentally disabled, and I believe to the elderly as well; yes.

Senator CHAFEE. Would you agree with that, Mr. Fulton?

Mr. FULTON. Yes, I would.

Senator CHAFEE. Now one of the problems with the ICFMR Program, as I see it, is the conflict between the policies, like the waiver, which are to move disabled people back to the community and at the same time the so-called look-behind process which is a detailed inspection and a levying of requirements by HCFA on the states to meet certain standards.

And it seems to me what we are doing in this is putting the States in the position of having to invest very substantial amounts of capital into their institutions and, thus, diminishing the chance of their ever having the funds available to develop a system of community-based facilities.

And is there any way of balancing this so that we can get the money so that the States can move ahead with the community facility?

Mr. CENSONI. Well, the look-behinds, first of all, I think there are some cases which have proved to be very important so I'm not speaking against those. But we have in our written testimony indicated ways in which we think dollars could be more wisely invested by moving into the community rather than continuing to remodel and to build up institutional systems. I think you touched, Senator, earlier on the fact that by making either the waiver longer or better yet by making it a permanent State plan amendment and perhaps putting in some disincentives for States to continue to use institutional services—if we are going to expand the community base because it's better, then we ought to do something about discouraging the use of larger institutions that we want to get away from.

If those things were put together, then you would see, I think, a much quicker and a much better community system developing; less costly and much more appropriate.

As it is right now, we are heading in the other direction, unfortunately.

Senator CHAFEE. Do you agree with that, Mr. Fulton?

Mr. FULTON. Yes, I would. I think there is a balance to be hit there. You cannot operate an institution that does not measure up to minimum standards, even while you are going through this process.

Senator **Chafee**. OK. My time is up.

But, Mr. Chairman, the point I'm trying to make here is that HCFA is levying requirements on the States to bring their institutions up to certain standards that require very, very substantial amounts of money. On the other hand there are many States desiring to develop small community-based facilities and services—where not only is the service for the individual far better, more personalized and appropriate, but also in some instances it is cheaper to have them there. These States are in a bind—the requirement is that if they are going to continue to get Medicaid, they have got to expend these millions on the institutions which they intend to close or at least phasedown in the near future.

We are in a classic conflict between Federal funding biases and the best system of care.

The **Chairman**. Senator Bradley.

Senator **Bradley**. Thank you very much, Mr. Chairman.

And thank you for your testimony.

I think State option is the preferred objective, I would like to ask Ms. Matula if we don't get State option this year, what other kind of things would you recommend? In particular, are you supportive of what was done in the House reconciliation bill where you limit per capita costs under the waiver to 75 percent of institutional care? Would you be supportive of the approach.

Ms. **Matula**. We are in favor of all of the recommendations in that House bill. They did not, however, address the limit on numbers who can participate. And that's a serious limit. It's ironic that we are limiting participation in the least costly service; whereas, we have open-ended participation in the more expensive institutional.

Senator **Bradley**. Mr. Censoni.

Mr. **Censoni**. Our stress would be—and it is in our written testimony—without getting into elaboration here, that we clearly define into law habilitation services, work-related services, and especially supportive employment. Those are essential if we are ever going to get off this dependency cycle that we are on.

Ms. **Matula**. And that's in the bill.

Senator **Bradley**. Would you support a waiver for 5 years? Extending the waiver from 5 years instead of 3 years? I think Senator Chafee mentioned that. Would that be helpful?

Ms. **Matula**. Yes, sir.

Senator **Bradley**. Would you support a freeze on the expiration of waivers for a 2-year period, like for a cooling-off period, to try to sort things out?

Ms. **Matula**. Yes; I would hope that it would catch me in that net as well.

Senator **Bradley**. Well, the effective date might be important there.

In your testimony you talked about HCFA regulations and how they really seemed to reward nursing home bed growth. It's almost as if the present system tells a State to build nursing homes and then leave beds vacant so that they could be eligible.

My question is: What's a better indicator than nursing homes?

Ms. **Matula**. Well, if you take the number of people who are institutionalized—and for the elderly population, if you would simply index that to the growth in the number of elderly at certain age levels—for the mentally retarded, it would be probably indexed to the general population growth, at least it would give you some room to reasonably grow. It's not a perfect measure, but it's a way to take what exists today and allow for some growth in that population tomorrow.

We are putting our heads in the sand if we think that the need for these services will stay the same or go away.

Senator **Bradley**. If you limited the nursing home bed growth to the growth of the elderly, and home services were increased, would you still not have too many nursing home beds?

Ms. **Matula**. You might. And, of course, we cannot control the entry into those beds by people who are not Medicaid eligible. A private-paying patient may enroll himself in a nursing home at any time. I don't know that you want to control that.

Mr. **Petit**. Senator Bradley, if I could respond to that. The State of Maine declared a moratorium on nursing home beds in 1979 after 500-percent increase in costs in about a 6 or 7 year period.

In the interim period what we have done is divert what would have otherwise been an increased expenditure for nursing homes into home-base care. The answer I think to your question is that you need a balance approach that requires both nursing home care, home-base care and other services.

It's working very, very well in our State. We have also put nursing homes on a prospective reimbursement system, which is something that I think you should consider.

And as for the private-pay patients, the reality is about 85 percent of them quickly become public-pay patients after a very short period of time. And the States could individually require that there be a classification and assessment of each of them before they enter a nursing home, or you could do a one-felded swoop by requiring the States to adopt that kind of a position, which I think would be a very strong and supportive position of where the States should be on this.

Senator **Bradley**. A concern that is expressed frequently on the State option approved is that there is no way to limit the population that would be eligible and suddenly a lot of people who weren't eligible would, in fact, come in under the program, and program costs would explode. That's OMB and HCFA's concern.

Meanwhile, some in the House have the opposite concern which is that if you gave States the option to run the program, it would be used to restrict services.

My question to you: In the previous panel there was a recommendation that we limit services to a very clear definition of what type of individual would be eligible. Is that a workable approach?

Ms. **Matula**. You mean a medical definition of those who would otherwise be in an institution?

Senator **Bradley**. Yes.

Ms. **Matula**. Yes; I think that's workable. That's how we are doing it for our limited population now.

Senator **Bradley**. Would you agree, Mr. Censoni?

Mr. **Censoni**. I think it could be done. Obviously, if that would incrementally get us closer to where we need to be in terms of the flexibility, we would definitely support it.

Senator **Bradley**. Mr. Petit.

Mr. **Petit**. No; I would not. I have yet to find an adequate definition of need at the Federal level for virtually any program. And the States do need more flexibility in this area.

Senator **Bradley**. Mr. Chairman, I had wanted to pursue a line of questioning on what Mr. Petit and Mr. Fulton had to say about employment opportunities for AFDC recipients. I would hope that they would produce for the record any written materials they would have regarding efforts of the States to reduce dependency.

Would you be willing to do that?

Mr. **Petit**. Certainly.

[The information from Mr. Petit follows:]

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WIN: A WORTHWHILE INVESTMENT

The Work Incentive program (WIN) is the only source of federal money specifically dedicated to helping recipients of the Aid to Families with Dependent Children (AFDC) achieve self-sufficiency. As such, it provides states with an indispensable resource in their efforts to establish efficient and effective employment and training programs aimed at reducing welfare dependency. Elimination of the program would severely damage the employment efforts and work program innovations now being undertaken by the states, further eroding the limited system now available to help low-income families attain economic independence through employment.

Program Description

WIN provides employment and training services for AFDC recipients who are required to register for work-related training. Program emphasis is on placing the maximum number of participants in self-supporting employment to reduce the nation's welfare assistance costs. A wide variety of techniques are used by the states to achieve this end, including; job search (i.e. job clubs, job development, orientation to the world of work, exposure to labor market information), work experience, on-the-job-training, and vocational and other classroom training.

In states operating regular WIN programs, the program is jointly administered by the state's employment service and public welfare agencies. The state employment service agency provides the employment and training services while the state public welfare agencyprovides the supportive services needed. Four years ago Congress granted states more flexibility to design and operate the WIN program by authorizing the WIN demonstration program. Under this program WIN services are administered entirely by state public welfare agencies. Presently, 22 states are operating WIN demonstrations.

WIN Accomplishments

Despite limited dollars, the states have had measureable success with WIN.

Nationwide, states registered over one million AFDC recipients for WIN services in FY 84. Roughly 35% of these registrants, 354,396, found jobs--38% more than in FY 83. **The resulting savings attributed to welfare grant reductions totaled $587 million; more than double the $260 million in federal money invested in grants to the states for this period.**

Individual states performance further exemplifies the success of both WIN and WIN demonstrations.

- In Vermont--a WIN state that has traditionally been successful in moving welfare recipients into paid employment--more than half of the total number of AFDC recipients registered for WIN services in FY 84, 3,626 of 6,065 entered jobs. In Washington, another state with a successful WIN program, 9667 AFDC recipients found jobs in FY 84, representing 48% of the 20,172 registered recipients. In Idaho the results are even more impressive, more than 75% of the 2,091 AFDC registrants-- 1580--entered employment.

- States that have opted to run WIN demonstrations have been equally as successful. Oklahoma had 19,727 AFDC recipients registered for WIN demonstration services by the end of FY 84 of which 7,716--39%--found jobs. In Arizona, 3,422 recipients entered employment representing 39% of the 8,782 registrants.

Further accomplishments are expected as state continue to improve their employment initiatives.

- The Department of Labor estimates that the number of recipients who will find jobs in FY 85 will increase to 372,115. This despite the fact the federal funding remained at nearly the same level as in FY 84.

- The Department of Health and Human Services in an evaluation conducted of WIN demonstrations found that in aggregate the number of individuals entering employment increased within the first year of the program's operation alone. Moreover the federal expenditures per entered employment had dropped in 13 of the 17 states reviewed.

The Impact of Program Elimination

Elimination of funding for WIN would end one of the most important routes to self-sufficiency available to welfare recipients who lack the skills and work experience to otherwise compete successfully in today's labor market.

In a state survey recently conducted by APWA, the 25 responding states reported that approximately 415,000 recipients would have no work program in which to participate, despite other employment and training programs available, if WIN funding was eliminated. Consider what the negative consequences would be accross all of the states.

WIN: PROFILE OF STATE PERFORMANCE (FY 84)

	Registrants	Placements	Program Costs (Millions)	Program Savings (Millions)
Arizona	8,782	3,422	$ 2.4	$ 5.9
Connecticut	21,527	4,213	4.7	8.0
Idaho	2,091	1,580	2.3	4.1
Kansas	14,372	2,122	2.1	4.5
Maine	3,585	1,343	1.5	3.1
Massachusetts	37,080	8,816	19.9	26.4
Virginia	41,761	8,274	5.2	13.2
Washington	20,172	9,667	12.2	36.0

Data collected by APWA survey, May 1985.

Registrants - Average number of mandatory and voluntary registrants on an annual basis.

Placements - on jobs, subsidized or unsubsidized.

Program Costs - total federal and state funds expended for direct agency staff, as well as employment, education and training activities.

Program Savings - AFDC grant reductions (does not include resulting savings in Medicaid and Food Stamps)

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman.

I would like to have any or all of you, but hopefully at least two of you, respond to my first question. Do you feel that the proposal to modify the AFDC quality-control program balances the need to be fair to the States that have done what I consider a relatively good job with getting things under control? Balancing that with a need to be sensitive to States that have legitimate problems meeting the error rate.

Mr. FULTON. Senator Grassley, I will take a crack at that one. I do believe that the Evans proposal and the Matsui proposal both are very constructive efforts to deal with that balance. They do not take the pressure off the States relative to continuing progress on error rates.

They do recognize, though, that there is some serious quirks and deficiencies in the current quality-control design. Examples, my State has had historically a very low error rate in AFDC. We ticked up just a little bit over the target; we get a penalty. Many other States are substantially higher than that in errors and because they have come down some, they don't get a penalty.

Now that's hard to accept in a State which has got tight management and is trying to improve the technical error question. There is just a whole host of things that these two bills will give a workable way of dealing with that I think will pull us out finally with a situation—with a set of rules that we can all defend.

The present situation is just—it is extremely punitive relative to the way it works on the States.

Mr. PETIT. Senator Grassley, virtually every State endorses both of those bills; thinks they would be a step in the right direction.

And I would note something that was raised earlier in someone's testimony or questioning. Part of the difficulty for the States is each of the three major income security programs—Food Stamps, AFDC and Medicaid—have become much more complicated to administer in the last 5 years. And we have literally had to double our administrative staff in those programs at the same time that we reduced our error rate by some 60 or 70 percent.

So, at some point, simplification and integration of those three programs eligibility requirements would also cause the error rate to go down.

Senator GRASSLEY. On another point, you use this term in your proposal called "lower bound estimate." First of all, I'd like to have some judgment from your point of view that that's statistically sound. But even more important, is this estimating method used in any other Federal program?

Mr. FULTON. That's an argument among the statisticians in part. It's a question of the error—the range of error. In setting the State performance reading, you use the lower bound of confidence or the middle point?

We believe that using the lower range would be reasonable, given the deficiencies that do exist in the definitions, in the basic data system. I'm not a statistician.

I understand that the process that we are using here was adapted from industrial practices on quality-control sampling. And that, indeed, while we may not be able to prove that it is being used in any other Federal program, in these three programs—Food Stamps, Medicaid and AFDC—we think there is a very credible argument for using the lower bound so that basically you give the states the benefit of the doubt on the error.

Senator GRASSLEY. A followup, then, that I didn't anticipate asking because I didn't realize the source of it. You say there is some use of it in industry. Is it generally accepted there, then?

Mr. FULTON. Well, in industry, as I understand the process, when you pull a product off the assembly line, you sample—you inspect it to make sure that it measures up to the specifications. That there is generally in that process a midrange approach. That's a fairly concrete specific kind of a thing to measure, however.

In this system, we are dealing with a lot of interpretative judgments. And, of course, we are dealing with human frailty. And the question of whether you apply rigidly a midrange approach to the definition of error is really what is involved here.

It's a highly technical subject. And I think that the question of midrange or lower bounds is one that is important. It is one that probably reasonable people could differ on.

Senator GRASSLEY. I want to ask a question that maybe requires a little philosophical response at this point because we are just starting to see problems.

Can I finish asking this question?

The CHAIRMAN. Sure.

Senator GRASSLEY. But it deals with what we refer to as a Katie Beckett waiver. She's a little girl from my State that you know is ventilator dependent. There is a growing number of these children that are very expensive to care for. And they do, in fact, create quite a drain on the Medicaid Program.

Is there a need, from your expertise, to look at some alternate funding sources? And I would say not just the public, but some sort of a cooperative effort between insurance efforts, other private source, and I suppose we would also have to involve HCFA in this. Is there any dialog within your profession?

Mr. FULTON. There is concern about the Katie Beckett waivers. We have got Medicaid experts here who probably can speak to that better than me.

I do think that this is sort of the ultimate in the catastrophic coverage question. It is, how do we pay for extensive care that is going to continue lifelong for a child who would otherwise be in a hospital. And we obviously would pay incredible amounts if they stayed in the hospital.

So I think the Katie Beckett waiver authority was a very useful set, myself. But it's not the ultimate answer.

Senator GRASSLEY. Do you have some thoughts along that line? Particularly, outside of just the Federal Treasury.

Ms. MATULA. Exactly. This is something that I think we need to have an open dialog with our insurance commissioners on because it is the ultimate in catastrophic coverage, just as long-term care is catastrophic coverage. Whether this or organ transplants, these kinds of things can make such a tremendous drain not only on a State budget, but if you have county participation, it can quadruple that county's expenditures. Do we want this to be a purely publicly supported program? If so, Medicaid and the waivers is an excellent way to go. Should we have some risk pooling on this? Most insurance companies liability is limited. Only Medicaid's is unlimited.

So, I definitely think we need the private sector to join with us in this. I'm not sure what cooperation we would get, though.

Senator GRASSLEY. I would like to say to the chairman that I have been doing some thinking along that line. Maybe other members have as well because I don't know who else is involved.

But I would like to ask the committee to take an elementary first step in this direction before we get done with the process of reconciliation. And I'm not talking about a proposal, but some approach of studying it so we can bring the thoughts together.

Ms. MATULA. Would you expand it to mean any large expenditure? Because we are now facing heart transplants, heart and lung transplants.

Senator GRASSLEY. I haven't gone that far.

Ms. MATULA. In terms of a catastrophic approach.

Senator GRASSLEY. I'm going to have to speak to some of the others members of the committee on it. But I just want to bring it to the good chairman's attention.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

I'd like to talk to Mr. Petit a minute on the testimony he gave, which I found very interesting and helpful.

On page 3 of your testimony you talk about sevices to prevent adolescent pregnancy. It seems to me that that proposal gets to the heart of one of the most troubling and massive problems we face in the country today. The statistics on adolescent pregnancies are overwhelming and discouraging. Something like nearly half a million adolescent pregnancies this year.

Mr. PETIT. There are about 1.2 million adolescent pregnancies and 600,000 adolescent abortions.

Senator CHAFEE. Well, that's even more than I thought. It's a tremendous number.

Do you have any particular program in mind that you can refer to or that you know of that seems to have worked?

Mr. PETIT. There is no single best way to approach this particular problem. There are two approaches that seem to be divergent in the public's opinion in terms of dealing with this issue.

One is to encourage kids to not have sex. And the second one is to provide kids with the contraceptives necessary to prevent pregnancy once they decide to engage in sex. There is a profound philosophic debate on that issue, as you know. The reality is that they are already engaged in sexual activity, and they are becoming pregnant in record numbers. And, most importantly, they are becoming pregnant and giving birth in record numbers out of wedlock, and are retaining their children.

We estimate that more than 90 percent of all young girls who are giving birth to babies are retaining their children out of wedlock. And on a national average, we are now approaching a 50-percent rate of out of wedlock births among teenagers.

I think that what it gets down to eventually is the perception by many of our young kids that they don't really feel they have options; they are not interacting much with adults; adults feel very uncomfortable in approaching them with this problem.

The truth is that parents and churches are not addressing this issue. Most schools are not addressing the issue. And the message that kids are getting comes from our national media.

And if you take a look at where the rock industry is, and where television and where Madison Avenue is, they spend morning, noon, and night pedaling sexuality to children as a means of marketing their goods.

And it is the height of hypocrisy for me that ABC, CBS, and NBC 2 or 3 weeks ago rejected the most modest public service announcement to present to our teenagers and the public on this whole question of using contraceptives. An ad, by the way, that was prepared by the American College of Obstetricians and Gynecologists, hardly, you know, a group that is promoting promiscuity.

So, I think sir, that the Federal Government, financially, has a very compelling reason to be interested in this problem.

Senator CHAFEE. Well, there is no question they have got a compelling interest because the cycle of teenage pregnancy, the teenage unwed mother, no education, illiterate in many instances or semi-illiterate, no job, and the feeding of the whole cycle of poverty continues from there.

Mr. FULTON. Senator Chafee——

Senator CHAFEE. Unless you have got a solution.

Mr. FULTON. I was only going to comment that we wind up with the mothers, teen mothers, in our AFDC Programs. And one thing you asked about was model programs.

I just wanted to comment that in Oklahoma we have a waiver of the aged child. And we are working intensely on the employment front with young mothers. Employment and training and education.

And that's making some headway.

Senator CHAFEE. I don't want to mix a metaphor, but that's after the horse is out of the barn, isn't it?

Mr. FULTON. That's true.

Mr. PETIT. Senator, the answer is to talk with kids about this. And when they decide to become sexually active, it's to be realistic about it and provide them with contraceptives. There isn't anything else.

Senator CHAFEE. No.

Mr. PETIT. And that's something that we all have a lot of problems with.

Senator CHAFEE. Thank you.

I don't know who touched on the issue of estate management. It was either Mr. Petit or Mr. Fulton. How frequent is the transfer of assets to a trust by potential beneficiaries? Who touched on this? Was that you, Mr. Fulton, in your testimony?

Mr. FULTON. I didn't directly comment on it, but that is a serious problem.

Senator CHAFEE. You know, the very word "trust" is a word that most people don't rush to—setting up trusts. That may be all right for wealthy people coming into the Federal Government, but I can't believe somebody with $30,000 or $20,000 rushes out and sets up a trust.

Mr. FULTON. We are making the funeral industry a banking trust company. I mean really that is such a serious problem in my

State I'm about to recommend that we just flaunt the Federal law and put a limit on it.

Senator **CHAFEE**. What do you mean? They rush out and pay for their funeral expenses or something like that?

Mr. **FULTON**. You set it up in burial trust of unlimited amount. And then after the burial is over, the family gets the distribution and they remain—I mean they have gotten care for the family in the meantime through the—for the elderly person through the Medicaid Program.

Senator **CHAFEE**. Is that right?

Ms. **MATULA**. This is a very serious problem. Both Business Week and now the New York Times have written articles advising people how to hide their money to become eligible for Medicaid for nursing home care.

Senator **CHAFEE**. Well, you learn something every day. I thought it was—somebody told me lawyers were advertising on how to do this. But it's the funeral industry.

Ms. **MATULA**. It's the New York Times right now.

Senator **CHAFEE**. And so you go to the funeral home and funeral director says give me $50,000 and I'll take care of your burial and anything that is left over—do they leave anything over?

Mr. **FULTON**. Well, quite often they do.

Senator **CHAFEE**. It must be a tremendous temptation not to.

So they handle that money in trust for the—gee, I wonder what the taxation ramification is? Who is the tax to? Well, maybe they avoid the problem by not paying any tax.

All right, thank you.

The **CHAIRMAN**. Senator Grassley.

Senator **GRASSLEY**. No questions.

The **CHAIRMAN**. Thank you very much, all of you, for coming. We appreciate it.

Now if we can move on to Mr. Dempsey, Mr. Kilroy, Mr. Myers and Mr. Snyder.

Let's wait just a minute for the people in the back who are leaving and then we will proceed.

If those in back who are leaving could move out and close the door, please, we would appreciate it.

All right, Mr. Dempsey, go ahead.

STATEMENT OF MR. WILLIAM H. DEMPSEY, PRESIDENT, ASSOCIATION OF AMERICAN RAILROADS

Mr. **DEMPSEY**. Thank you, Mr. Chairman.

I am accompanied by Mr. Charles Hopkins, who is the chairman of the National Railway Labor Conference, the bargaining arm of the industry. Both he and I served as management members of the Railroad Unemployment Compensation Committee that was established by Congress in the 1983 legislation to review the problems that beset the unemployment system of the railroads.

Dr. Myers, as you know, is the chairman. Mr. Kilroy, who is with us, is a union representative, and he was joined on the union side by Mr. John Sytsma, president of the Brotherhood of Locomotive Engineers.

The system is in difficulty, as you know. During the last recession, we dropped about 20-odd percent of our employees.

The CHAIRMAN. Hold on just a minute.

Could we close the door to the room, please, or quiet down the hallway?

Go ahead.

Mr. DEMPSEY. And that put the whole system into a tailspin. We borrow not from the Treasury as the States do, as you know, but rather from our own railroad retirement account. And at the present time, the debt of the unemployment account to the retirement account is in the range of $800 million. And, obviously, that debt has got to be taken care of.

The Railroad Unemployment Compensation Committee has made its recommendations to the Congress, and I'm sure that Dr. Myers will review those recommendations with you. They are set out in our testimony.

I would like to make several points about those recommendations. In the first place, this is a matter of grave urgency. Under the 1983 legislation, the authority of the unemployment account to borrow from the retirement account expires at the end of this month. The Retirement Board has now issued regulations under which as of October 1, benefits will be reduced by 20 percent, and the railroads will be called upon to pay 8 times a month instead of quarterly. This will impose a grave burden upon us, both in terms of cost and administrative difficulties, and, of course, it will be;a hardship on the employees. So, something needs to be done very promptly.

The committee explored basically two approaches: One, the one recommended by the administration which is to abolish the Federal system and go to the State-Federal system in all the States.

And the other was to restructure the existing system.

The difficulty with abolishing the present system, in our judgment, is a financial problem. The unions have other problems with it. But from our perspective, the problem is that the administration's program would cost the railroads about $1.6 billion more than the recommendations that the committee has made to restructure the present system by the year 2000.

And, accordingly, we, on the management side, join with Dr. Myers and with our union colleagues in recommending a restructuring of the present system.

One essential element in the recommendations of the committee has to do with the interest problem. A very large part of the debt is accounted for by interest. And, accordingly, since it is simply interest owed not to the Federal Government but rather to ourselves, that is, the railroad retirement account, and since it is clear that the railroad retirement account is in good shape, the committee recommends forgiveness of that interest.

The only relevant issue, it seems to us, would be whether that would threaten the fiscal integrity of the retirement account, and it would not.

There is an alternative approach. And that has been recommended by the Retirement Board. Pursuant to the 1983 legislation, the Retirement Board must report to the Congress on the status of the retirement account each year, and recommend whether or not a part of the railroad tax could be diverted to help in taking care of the unemployment debt.

And the Board has so recommended. That is to say, a 1-percent diversion. They estimate that that would—together with the repayment tax that was imposed on the railroads in 1983—pay off the whole debt with interest by 1989 or 1990.

That, to us, is an acceptable alternative to forgiveness of the interest. But one or the other, we submit, really must be done.

That is the main problem. And I will conclude my remarks by drawing your attention to H.R. 3128, reported by the House Ways and Means Committee. That bill simply imposes staggering taxes upon the rail industry. It does nothing about restructuring the benefit system at all. And that was the union's contribution—restructuring of the benefit system to reduce our costs by about 11 percent a year.

And it does nothing with respect to either forgiveness of interest or diversion of the rail retirement tax. And, therefore, it imposes this, we think, awful burden upon the industry. Our taxes in 1988 could be as much as 17½ percent of taxable payroll.

The CHAIRMAN. Say that again.

Mr. DEMPSEY. Our taxes in 1988, under the House bill, could be as high as 17½ percent of taxable payroll. Just for the unemployment part of our taxes.

The CHAIRMAN. I understand.

Mr. DEMPSEY. All of that—without taking care of the problem because even this would not pay off the debt.

So, what we urge upon the Senate and upon this committee, Mr. Chairman, is an integrated approach along the lines of the recommendations of the Railroad Unemployment Compensation Committee.

Thank you.

The CHAIRMAN. Thank you, Mr. Dempsey.

[The prepared written statement of Mr. Dempsey follows:]

JOINT STATEMENT OF

WILLIAM H. DEMPSEY
PRESIDENT, ASSOCIATON OF AMERICAN RAILROADS

AND

CHARLES I. HOPKINS, JR.
CHAIRMAN, NATIONAL RAILWAY LABOR CONFERENCE

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ON

REVISION OF THE RAILROAD UNEMPLOYMENT
AND SICKNESS INSURANCE SYSTEMS
(DEFICIT REDUCTION)

September 13, 1985

William H. Dempsey is the President and Chief Executive Officer of the Association of American Railroads, and Charles I. Hopkins, Jr. is the Chairman of the National Railway Labor Conference. The AAR represents almost all of the nation's Class I railroads in a wide variety of matters, including legislative matters, that concern the railroad industry. The NRLC represents almost all of the nation's Class I railroads in national collective bargaining with representatives of their employees and in regard to other matters concerning labor-management relations in the railroad industry, including negotiations with the railroad unions upon recommendations to be made to the Congress in regard to the Railroad Unemployment Insurance Act ("RUI Act"). Thus, we are the principal officers of the two railroad associations directly concerned with unemployment compensation legislation affecting the railroad industry.

We also are the two management members of the Railroad Unemployment Compensation Committee ("RUC Committee") established by Section 504 of the Railroad Retirement Solvency Act of 1983 (P.L. 98-76) to review the railroad unemployment and sickness insurance systems ("RUI system") established by the RUI Act and to submit a report and recommendations to the Congress. The fact that we served on that Committee, and participated personally in its numerous meetings, reflects the importance which the railroad industry places upon legislation restructuring unemployment compensation in that industry.

We appreciate this opportunity to appear before the Committee on behalf of our associations and their member railroads. We recognize that the broad subject to which the Committee's hearings are directed, deficit reduction, involves many matters in addition to the RUI system. While we share the general concern about the deficit, any legislation that affects the RUI system directly affects the railroad industry and this Joint Statement primarily is limited to that subject.*/ The RUC Committee has recommended a balanced program for restructuring the RUI system in a manner that should restore and assure future financial solvency through benefit changes as well as tax increases in a manner that is fair to all concerned. That program has the support of both the railroads and their employees. The Railroad Retirement Solvency Act of 1983 enacted a similar program in regard to the railroad retirement system, which has successfully restored the financial solvency of that system, as well as laying the groundwork for such an approach to the RUI system through its creation of the RUC Committee.

We are deeply concerned that the Congress may lose this opportunity for a thoroughgoing and balanced restructuring of the RUI system through a narrow concentration upon the tax aspects alone as a part of broader deficit reduction legislation. In the past, when both the tax and the benefit aspects of the railroad systems may be affected, while the respective House and Senate Committees having jurisdiction over either the tax or benefit aspects of the legislation have generally limited their direct recommendations to that aspect over which such jurisdiction exists, that has been done in regard to a single bill in a coordinated effort to treat all aspects of the problem before the Congress. That was what was done in regard to the Railroad Retirement Solvency Act of 1983, for example, and that is what we urge be done in regard to legislation restoring the financial solvency of the RUI system.

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*/ We also discuss a provision in H.R. 3128 that would adversely affect the railroad retirement system.

But even if the Committee should deal with unemployment insurance taxes as a part of broader deficit reduction legislation, it should not recommend legislation in that regard that is inconsistent with the tax aspects of the program recommended by the RUC Committee and incompatible with other aspects of that program, and that would place the entire burden of restoring the financial solvency of the RUI system upon the railroads alone. Unfortunately, that is the approach that was followed by the House Ways and Means Committee in Title IV of H.R. 3128, reported on July 31, 1985. The railroads are strongly opposed to that aspect of H.R. 3128 and urge that its approach be rejected by this Committee and by the Congress.

INTRODUCTION

The RUI Act was enacted in 1938 to provide an unemployment compensation system, effective July 1, 1939, for unemployed workers in the railroad industry. 45 U.S.C. §§ 351 *et seq.* In general, under the RUI system the circumstances in which unemployment benefits are payable, the daily amount payable and the maximum period for which benefits may be paid are identical for similarly situated individuals regardless of the location of their work or residence. The payment of those benefits is financed through unemployment "contributions" or taxes imposed upon the railroads with respect to compensation paid to their employees at a rate that is identical regardless of where the particular railroad operates. If the revenues from those taxes are insufficient fully to fund the payment of benefits, as may occur in periods of high unemployment, the Railroad Unemployment Insurance Account ("RUI Account") borrows the necessary additional funds from the Railroad Retirement Account, which borrowings are repayable with interest.

Effective with the establishment of the RUI system on July 1, 1939, the railroads and their employees were taken out from under the coverage of the previously established federal-state unemployment compensation ("UC") system which continues to provide unemployment compensation to unemployed workers in other industries. Each state has its own UC system that in general is governed by the laws of that state, including such things as the circumstances in which a benefit is payable, the amount of the benefit payable, the length of the period for which it may be payable, and the taxes imposed upon covered employers for use in funding the payment of those benefits. Thus, those and other essential features of an unemployment compensation system may vary from state to state. However, the Federal Unemployment Tax Act ("FUTA") imposes a federal unemployment tax (now 6.2% of wages up to a $7,000 annual maximum), most of which (in general, all but 0.8%) may be offset by credits for state unemployment taxes paid to states that comply with certain specified standards or requirements (as uniformly is done). See 26 U.S.C. §§ 3301 et seq. Among other things, when revenues from unemployment taxes are insufficient to pay full benefits, a state UC system may borrow the necessary additional funds from the Federal Unemployment Account (and thus in effect from the General Treasury), which borrowings are repayable without interest if made before

April 1, 1982 and repayable with interest if made thereafter. See 42 U.S.C. §§ 1104(g), 1321-1324.

A 1946 amendment to the RUI Act established a system of sickness insurance benefits for railroad employees, effective July 1, 1947. 60 Stat. 722. In general, the benefits payable, the qualifying requirements (other than requiring sickness rather than unemployment), etc., are similar or identical to those provided in regard to unemployment, and both types of benefits are payable out of the RUI Account from the revenues generated by employer contributions or taxes plus any necessary borrowings from the Railroad Retirement Account. Although five states and Puerto Rico have established systems providing sickness benefits in some circumstances, in general other industries are not subject to even a roughly comparable statutory sickness insurance system at either the state or federal level.

The independent RUI system operated without any serious financial problems for over four decades. For example, all loans from the Railroad Retirement Account had been repaid so that none were outstanding in either FY 1979 or FY 1980. However, during the severe 1981-83 recession average railroad employment dropped from 503,000 in calendar year 1981 to 398,000 in 1983. This decline of more than 20% naturally had a severe impact upon the RUI system. By the end of FY 1983, outstanding borrowings from the Railroad Retirement Account amounted to $575 million and that debt has increased because of the interest burden even though the economic recovery that was then underway brought about stability in railroad employment and a declining rate of unemployment. Moreover, while the Railroad Retirement Account is funded through railroad retirement taxes paid by the railroads and their employees, so that in effect such borrowings were from the railroad industry's money, the Railroad Retirement Account also was in financial difficulty by reason of the recession as well as other factors.

The Railroad Retirement Solvency Act of 1983 dealt fully and effectively with the financial problems of the railroad retirement system, including both increases in the railroad retirement taxes payable by the railroads and their employees and reductions in benefits otherwise payable to retirees. That system is now solvent and, according to the estimates of actuarial experts, is expected to remain solvent for the foreseeable future. The 1983 Act also included some interim measures to improve the financial condition of the RUI system, including a 50% increase in the unemployment taxes payable by the railroads through an increase in the monthly maximum taxable compensation from $400 to $600 effective January 1, 1984.

The Congress did not in that 1983 legislation, however, undertake a full or permanent solution to the financial problems of the RUI system. Rather, Sec. 504 of the Act provided for the establishment of the RUC Committee, comprising two members selected by railroad management, two members selected by railroad labor, and a fifth neutral member (Chairman) selected jointly by the partisan members. The RUC Committee was directed to "review all aspects" of the RUI system, including "alternatives to the railroad unemployment insurance system such as covering railroad employees under the Federal-State unemployment compensation system." The Committee was further directed to report its recommendations to the Congress, including recommended means for repaying all loans from the Railroad Retirement Account "before December 31, 2000."

The Congress also in effect provided incentives for agreement upon a workable solution. Under Sec. 302 of the 1983 Act, the authority of the RUI Account to borrow from the Railroad Retirement Account is terminated as of September 30, 1985, so that payment of unemployment and sickness benefits after that date will not be assured unless the necessary legislation is enacted before that date. In addition, Sec. 231 of the 1983 Act imposes upon the railroads a Railroad Unemployment Repayment Tax, effective from July 1, 1986 through September 30, 1990. The Ways and Means Committee, which originated that provision, noted, among other things, that it was not intended to forestall "careful consideration [of] any alternative mechanism for the repayment" of the loans from the Railroad Retirement Account that might be recommended by the RUC Committee. H. Rept. No. 98-30 (Pt. 2) at 39.

As noted at the outset of this Statement, we were the management members of the RUC Committee. That Committee was very fortunate to have the services of Dr. Robert J. Myers as its public member and Chairman. While we did not always agree with Dr. Myers, we have no doubt of his impartiality, fairness, expert knowledge, and unfailing patience and courtesy, and we are pleased to have this opportunity to express our deep appreciation for his services. It was also a pleasure to work with the labor members of the Committee -- Messrs. Richard Kilroy and John Systma. The Committee also received extensive technical assistance from the Railroad Retirement Board and its staff.

The final Report of the RUC Committee ("Report"), dated June 29, 1984, has been submitted to the Congress. As the Committee stated on page

3-1 of its April 1, 1984 interim report to the Congress --

> ". . . the approach of the Committee will be to examine two alternatives -- (1) maintaining the RUI program in its present independent form and (2) merging the RUI program into the state programs, with special emphasis on the necessary transitional provisions. The Committee will develop what it believes to be the best way to implement each of those two concepts before passing judgment on its final recommendations."

A consensus agreement was reached by all members of the RUC Committee in regard to "the best way to implement" continuation of an independent RUI system. That "consensus package" of proposals which would place the RUI system on a sound financial footing, including repayment of the loans from the Railroad Retirement Account before the end of the year 2000, also constituted the final recommendation of Dr. Myers and the labor members for legislative action by the Congress. The labor members were unalterably opposed to any proposal for terminating the RUI system so as to bring railroad employees within the coverage of the federal-state UC system. The management members reached agreement with the Chairman on principles to be recommended in that regard, and we also favored coverage of the railroad industry by the federal-state UC system if that could be done through provisions that would not impose undue burdens upon the railroads.

While we continue to believe that that approach is sound in principle, on the basis of the information now available to us we have concluded that it is not now feasible as a practical matter. Thus, we now believe that the consensus package recommendations for continuing the RUI system are to be preferred to the alternatives that we have reviewed. Our position has changed as a result of occurrences since the Report of the RUC

Committee that have led us to conclude that there appears to be no reasonable prospect for the enactment of legislation placing the railroads under the coverage of the federal-state UC system in a manner that would not be prohibitively costly to the railroads.

While the Office of Management and Budget ("OMB"), without awaiting the RUC Committee's Report, had proposed in the FY 1985 budget legislation (subsequently introduced in the last Session of the Congress as H.R. 6068) for a transition to coverage by the federal-state UC system in a manner that was plainly objectionable to the railroads, we had thought that there was at least some prospect of reaching agreement with OMB (particularly in the light of the Report) upon a proposal that would be acceptable to the railroads. However, our efforts to do so have not been successful and, indeed, the legislation proposed this year by OMB appears to be even more costly -- and thus even more objectionable -- to the railroads. Hence, we do not now see any prospect of reaching an agreement with OMB upon proposed legislation for federal-state coverage that the railroads can support.

Moreover, with the agreement of OMB, our experts did work closely with experts at the Department of Labor in further refining a methodology for estimating as accurately as possible the costs of coverage by the federal-state system so as at least to reach common ground in that regard. This effort has made clear that even the suggestions we made in the Report of the RUC Committee for a transition to coverage by the federal-state UC system would be much more costly to the railroads than would enactment of the consensus package. The estimated costs to the railroads for the years 1986-2000 is $3.22 billion if the RUI system is continued as revised in accordance with the consensus package. The estimated cost is $3.85 billion if the railroad industry is covered by the federal-state UC system in accordance with the transition we suggested in the RUC Committee Report, or $630 million more. If the Administration's proposals for coverage of the railroad industry by the federal-state system should be enacted, we estimate that the cost to the railroads during that 1986-2000 period would be $4.82 billion, or some $1.6 billion more than the cost of the consensus package.

The consensus package has the further advantage of according with the preferences of our employees as expressed by their union representatives. Even though higher unemployment benefits would be payable on an average or overall basis if railroad employees were covered by the state UC systems, the RUI system provides a uniform benefit rather than one that varies as between the various states, the RUI system provides a benefit in some circumstances where a benefit would not be payable by the state systems, and the centralized RUI system avoids any question as to what system is applicable to a particular employee. Such considerations might be outweighed by the logic, at least from the viewpoint of the railroads, of transferring to the federal-state system if the cost were not prohibitive. In circumstances where it has become apparent that the overall cost of complying with the desires of the employees will be far less than any likely alternative, obviously it is in the interest of the railroads to join forces with their employees from the standpoint of labor-management relations as well as from an immediate monetary standpoint. We submit also that it is in the public interest to enact legislation that directly affects only the railroad industry, would be less costly to the industry than any likely alternative, and is supported by both railroad management and railroad labor.

THE CONSENSUS RECOMMENDATIONS OF THE RUC COMMITTEE FOR CONTINUATION OF A REVISED RUI SYSTEM

In agreeing to a consensus package concerning the best way to continue a revised RUI system the members of the RUC Committee necessarily had to compromise their individual views. While we individually believe that some aspects of the RUI system could be further improved, we are satisfied that the consensus recommendations will result in a financially viable system that is acceptable to both the railroads and their employees. Before elaborating upon the essential elements of the consensus package, we want to emphasize as strongly as we can that it is an integrated package, each element of which is vital to the consensus agreement, and we urge that it be adopted by the Congress without significant change.

The actuaries estimate that the RUI system would be in sound financial condition if the consensus package should be enacted. This would be achieved through a combination of (1) modifications in employee benefit provisions, (2) increases in maximum employer contributions or taxes, (3) improved administration of the system (including experience rating), (4) a one-time federal payment intended to provide some recompense for past discriminatory treatment of the system as compared to the state systems, and (5) a set aside of interest on the debt to the Railroad Retirement

Account. The consensus package also provides for repayment of the system's debt to the Railroad Retirement Account by the end of the year 2000. All interested parties -- the railroads, their employees, and the federal government -- would make some sacrifices, although most of the burden of placing the RUI system on a sound financial basis would be borne by the railroads and their employees.

Benefits payable. The maximum daily benefit now payable for both sickness and unemployment is $25, which is the equivalent of $125 per week. 45 U.S.C. § 352(a). That maximum amount (which is payable to almost all beneficiaries) has not been increased since 1976. It is recommended that the daily maximum be increased to $27, and that the $25 amount be indexed for future benefit years by two-thirds of the increase in national average wages. See Report at 3-25 and 3-26.

A $27 daily benefit is equivalent to a $135 weekly benefit, while the average weekly benefit that would have been payable to railroad employees by the state UC systems, as weighted by railroad employment in the various states, amounted to $160.70 in January 1984. See Report at 4-3. In view of that fact and the further fact that RUI benefits have not been increased since 1976, the proposed $2 increase in the existing maximum daily benefit is both a modest and a defensible increase.

The proposed two-thirds indexing (which would be supported by a comparable indexing of the taxable wage base) also is a substantial, and in our view critical, element in assuring that the solvency of the RUI system will not be undone in future years. Obviously, two-thirds indexing is preferable from a financial point of view to the 100% indexing utilized by the state UC systems that index benefit levels and also utilized for social security and tier 1 railroad retirement benefits. And, we are convinced that in the long run it will result in lower total benefit costs than would a system of occasional, but relatively large, increases which is likely to occur if some indexing is not provided. Moreover, the gradual increases afforded through a statutory indexing procedure should avoid the necessity of future resorts to the Congress for legislated specific increases.

Tighter qualifying requirements. Under present law, in order to be eligible for unemployment and sickness benefits, an employee must have earned at least $1,500 in creditable wages during his base year, which generally is equivalent to about two and one-half months of employment since no more than $600 may be credited in any month. In addition a new hire must have had compensated service in at least five months of the base year. 45 U.S.C. § 353, as amended by Sec. 411 of P.L. 98-76. It is recommended that the qualifying base-year compensation be increased to five times monthly maximum compensation, and that all employees be required to have compensated service in at least six months of the base year, effective July 1, 1985. See Report at 3-27. This will provide greater assurance that benefits are limited to regular employees, and will result in savings estimated at $242 million through the end of the year 2000.

Benefits now are payable for each day of unemployment or each day of sickness during 14-day registration periods, but excluding four of those fourteen days. 45 U.S.C. § 352(a). Since the four excluded days in effect allow for normal rest days, this means that there presently is no effective waiting period before benefits are payable. It is recommended that benefits be payable for only seven of the 14 days in the first registration period, which in effect would provide a three-day waiting period. See Report at 3-28. While most state systems require a one-week waiting period before unemployment benefits are payable, this recommendation will result in substantial savings to the RUI Account, as well as coming closer to approximating state requirements. Those savings are estimated to amount to $135 million through the year 2000.

Stated in different terms, it is estimated that these two recommended tightenings of qualification requirements together will reduce the total benefits otherwise payable by over 11%.

Unemployment taxes payable and experience rating. Under § 8 of the RUI Act, the unemployment tax rate imposed upon the railroads may vary from 0.5% to 8% (depending upon the balance in the RUI Account as of September 30) and that rate is applied to monthly compensation or wages up to a $600 maximum. 45 U.S.C. § 358, as amended by Sec. 503 of P.L. 98-76. Since the RUI Account is in debt to the Railroad Retirement Account, the tax rate is now 8%. Unlike the state UC systems, the RUI Act does not now provide for experience rating so that all the railroads pay the same tax rate regardless of the employment experience of a particular railroad's work force. It is recommended that the maximum tax rate be increased to 12% of monthly taxable compensation; that the actual rate payable by a particular railroad be determined by experience rating (subject to that maximum), except that a surcharge would be imposed on all employers in the event that the balance in the RUI Account reaches an unacceptably low level; and that the monthly maximum on taxable compensation be indexed in a manner comparable to the indexing of the daily maximum benefit (i.e., on a two-thirds basis). See Report at 3-11 through 3-19.

By basing an employer's effective tax rate in large measure upon the relative extent to which that employer's work force is employed or unemployed, an incentive is provided both to keep employment as high as otherwise is feasible and to police claims for unemployment benefits so as to determine whether those claims are justifiable. The latter function would be facilitated by a further recommendation of the RUC Committee under which affected employers would have a right to participate in the claims process, and thus to provide relevant information and to object to claims that do not appear to be justifiable, including resort to judicial review if necessary. See Report at 3-28. While employers have that right under the state UC systems, no such right is now provided by the RUI Act. It is anticipated that these recommended changes would reduce the unemployment rate, and thus the cost of unemployment benefits, although the amount of any savings has not been quantified.

The recommended 12% maximum appears to us to be as high as one reasonably can go. A railroad experiencing a relatively high level of unemployment is likely to be in financial difficulty already, and it is important to avoid a situation where the unemployment tax rate payable could go so high as to endanger the railroad's continued existence. The recommended indexing of the taxable wage base will prevent that maximum from in effect being eroded, as well as keeping the applicable tax rate at a relatively stable level. By providing for surcharges (ranging from 1.5% to 3.5% of taxable compensation) if the balance in the RUI Account falls below specified levels, there will be virtually complete assurance that any future borrowings by the RUI Account will either be avoided or promptly repaid. On the other hand, a tax credit would be afforded if the balance in the Account reaches an unnecessarily high level, and thus would avoid tying up more funds in the Account than can be justified. See Report at 3-18. In addition, the revenues produced by an 0.65% rate as applied to taxable compensation would be paid into the RUI Administration Account to defray administrative costs so that all employers would pay at least that rate, subject to a spill-back if the balance in that Account exceeded $6 million. See Report at 3-19 and 3-20.

We have noted that the Railroad Retirement Solvency Act of 1983 included an interim measure in regard to the RUI system that increased normal unemployment taxes paid by the railroads by 50% through an increase in the monthly maximum on taxable compensation from $400 to $600. That increase and the further increases made possible by the foregoing recommendations will result in a total increase in normal unemployment taxes estimated to amount, through the year 2000, to almost $1.5 billion dollars as compared to the taxes that would have been paid under the RUIA as it read prior to 1983 legislation. The increase would be from a total of about $2.15 billion to a total of some $3.646 billion. This enormous tax increase would be in addition to the repayment tax discussed below, which would add another $574.6 million for an overall estimated total increase of approximately $2.071 billion in the unemployment taxes paid by railroad employers through the year 2000.

Repayment of the debt to the Railroad Retirement Account. The RUI Account was in sound financial condition through the 1970s, and did not have any outstanding loans from the Railroad Retirement Account at the end of FY 1979 and FY 1980. Report, App. D, Table 4. As a result of the 1981-83 recession, plus the delayed unemployment effects due to federal legislation relating to the prior bankruptcies of the Milwaukee and Rock Island railroads and the predecessors of Conrail, railroad unemployment decreased by more than 20% from an average of 503,000 in 1981 to 398,000 in 1983. Id., Table 3. Unemployment benefit outlays increased from $122 million for benefit year 1979-80 to $387 million for benefit year 1982-83. Id., Table 7. Unprecedented unemployment outlays, together with the high interest rates charged on loans that were necessary to meet unemployment costs, resulted in a debt to the Railroad Retirement Account in the amounts of $115 million as of the end of FY 1981, $286 million as of the end of FY 1982, $575 million as of the end of FY 1983 (id., Table 4), and some $716.5 million as of December 31, 1984 (of which $576.3 million represented principle and $140.2 million represented interest). The RUC Committee estimated that the debt would be repaid by the end of the year 2000, if existing law is not changed, only under Employment Assumption I, while the debt was estimated to amount to $1.564 billion under Employment Assumption II and $2.393 billion under Employment Assumption III by the end of the year 2000, again assuming no change in current law. Report, App. E, Tables B-I, B-II and B-III.

The RUC Committee recommended that interest on that debt (after September 1980) be set aside, and that the principal be paid through a restructured repayment tax imposed at a rate which, as adjusted from time to time if necessary, would assure full repayment before the end of the year 2000. See Report at 3-7 through 3-10.

A crucial aspect of the recommended set aside of interest is that it concerns the debt that one railroad account owes another railroad account. The revenues for both accounts come from the same source: the railroad industry through payroll taxes paid by railroad employers and employees. Accordingly, the critical question should be whether the set aside would significantly imperil the solvency of the Railroad Retirement Account. If not, the set aside in effect would constitute a reasonable and prudent use of railroad industry payroll taxes for a more necessary purpose.

The members of the RUC Committee concluded that the solvency of the Railroad Retirement Account would not be significantly imperiled by the set aside which they recommend. See Report at 3-8. This was the conclusion not only of the management and labor members, but also of Dr. Myers who has actuarial experience and reputation that can hardly be surpassed. That conclusion is not surprising when it is realized that the assumptions underlying the forecasts utilized during consideration of the Railroad Retirement Solvency act of 1983 did not include payment of interest on the debt owed by the RUI system. Moreover, the employment assumptions utilized in that regard thus far have been much too pessimistic. They ranged from a high of 385,000 in 1983 and 370,000 in 1984 to a low of 360,000 in 1983 and 310,000 in 1984, while in fact railroad employment averaged 398,000 in 1983 and 396,000 in 1984.

The possibility that the 1983 Act could result in excess railroad retirement tax revenues that appropriately could be utilized in repaying the debt owed by the RUI system was recognized by the Congress when it provided, in Sec. 502 of that Act, for reports on the actuarial status of the railroad retirement system including whether "any part of the" tier 2 railroad retirement tax "should be diverted to the Railroad Unemployment Insurance Account to aid in repayment of its debt to the Railroad Retirement Account." In effect, that is precisely what the proposed forgiveness of interest would do. This seems simpler than an express revision of the tier 2 tax so as to divert the necessary portion of the proceeds to the RUI Account, but the railroads have no objection to such an approach if it is preferred by the Congress.

The Railroad Retirement Board has recently submitted to the Congress its first report under Sec. 502, as a part of its Sixteenth Actuarial Valuation of the railroad retirement system. The Board's Chief Actuary has recommended that "one percent of tier 2 payroll [tax receipts] be diverted to the Railroad Unemployment Insurance Account starting in 1986 to aid in the repayment of the debt to the" Railroad Retirement Account. Sixteenth Actuarial Valuation, Part C, at 17. That recommendation was made under "the conditions that (a) any extension of the unemployment account's authority to borrow from the railroad retirement account beyond September 30, 1985, is accompanied by a mechanism (other than further diversion of tier 2 taxes) which will ensure swift and full repayment of such future loans, (b) the portion of tier 2 taxes which is diverted to the unemployment account is rechanneled back to the retirement account once the debt is repaid, and (c) other forms of repayment to the retirement account, such as the Railroad Unemployment Repayment Tax, are left to operate as they would have in the absence of the recommended supplementation." *Id.* at 3. The Chief Actuary estimates that the debt to the Railroad Retirement Account (both principal and interest) would be "repaid by 1989 or 1990" if that recommendation is adopted. *Ibid.* His recommendation was endorsed by the Board's independent Actuarial Advisory Committee (*id.*, Part B, at vii) and by the Board itself (*id.*, Part A, at iv).

The railroads prefer the approach recommended by the RUC Committee since stretching out repayment of the debt through the year 2000, as was contemplated by the Congress in the 1983 Solvency Act, would alleviate to some extent the immediate impact of this additional tax burden. Nonetheless, the railroads are willing to accept the alternative thus recommended including the conditions specified by the Chief Actuary. In any case, the Sixteenth Actuarial Valuation confirms the conclusion of the RUC Committee that the solvency of the Railroad Retirement Account would not be significantly affected by either the set aside of interest recommended by the RUC Committee or the alternative temporary diversion of a small portion of tier 2 tax receipts. Even under the most pessimistic actuarial assumptions, the Account would not experience cash-flow problems before 2005 and it would experience such a problem in that year (in a slightly smaller amount) even if such a diversion or set aside is not enacted. See Sixteenth Actuarial Valuation, Part C, at 17.

It is also important to note that, under Sec. 502 of the 1983 Solvency Act, the Board will continue to submit by June 30 of each year annual reports to the Congress of the actuarial status of the railroad retirement system with recommendations for any financing changes that may be desirable. Hence, if either an interest set aside or a tier 2 tax diversion should result in presently unanticipated problems insofar as the railroad retirement system is concerned, the Congress should be so advised with ample time to take corrective action. The railroads and railroad unions in the past have cooperated in working out agreements upon recommended mutual sacrifices that appear necessary to the solvency of either the railroad retirement or the RUI system, and we expect that to be true in the future if the occasion should arise (which we do not now anticipate).

In short, either the approach recommended by the RUC Committee or that recommended by the Railroad Retirement Board would constitute a prudent utilization of payroll taxes paid solely by the railroad industry for a purpose for which they are needed instead of one for which recent tax increases have proven excessive. The benefits payable to railroad retirees will continue to be paid in full as will railroad retirement taxes, and both the railroads and their current employees will make substantial sacrifices towards restoration of the financial solvency of the RUI system under other aspects of the consensus package recommendations. Both the railroads and railroad employees (through their unions) support the set aside of interest and substitute repayment tax recommended by the RUI Committee, both are willing to accept the tier 2 tax diversion alternative (including retention of the existing Repayment Tax unchanged), no other taxpayers will be affected in any way, and the solvency of the railroad retirement system will continue to be assured.

Future borrowings by the RUI Account. As we have noted, Sec. 302 of the Railroad Retirement Solvency Act of 1983 terminated the authority of the RUI Account to borrow from the Railroad Retirement Account effective September 30, 1985. It is recommended that the RUI Account be authorized to borrow, after that date, from the general fund of the Treasury, in a manner similar to that now afforded by the state UC systems (through the Federal Unemployment Account) from the general fund of the Treasury. See Report at 3-24 and 3-25.

Some kind of borrowing authority is an essential feature to any rational unemployment compensation system, as it permits benefit and tax levels to be maintained on a relatively even keel despite temporary swings in the unemployment rate. Nonetheless, as the RUC Committee noted, the "consensus package has been developed in such a manner [that] such borrowing authority would rarely be used" and, if used, "the loan would be repaid within one or two years." Report at 3-24. Indeed, while the recommended borrowing authority generally would approximate that now afforded to the state UC systems, including the interest payable, even stronger assurances would be provided in regard to a speedy repayment with interest. If not repaid by the September 30 following the loan, a 3.5% surcharge would be imposed on the unemployment tax rate payable by the railroads during the next calendar year and, if the debt has not been fully repaid with interest by the following September 30, during succeeding calendar years as well. See Report at 3-24.

A one-time $135 million federal grant. The RUC Committee recommended that a "grant of $135 million should be made on October 1, 1985 by the General Fund of the Treasury to the RUI Account, so as to equalize for past preferential treatment given to the state UI systems by the General Fund." Report at 3-21.

Prior to April 1, 1982, the state UC systems could obtain interest-free loans from the general fund of the Treasury through the Federal Unemployment Account, and even now the interest payable is subject to a 9 or 10 percent cap, and payment may be suspended or deferred in some circumstances. Moreover, the Extended Unemployment Compensation Account has been and still is authorized to obtain interest-free loans from the general fund when necessary to pay the 50% federal share of extended unemployment benefits paid by the federal-state UC system pursuant to the Federal-State Extended Unemployment Compensation Act of 1970. In contrast, the borrowings by the RUI Account from the Railroad Retirement Account always have been repayable with interest, and the latter Account is funded from railroad retirement taxes rather than from the general fund. See Report at 3-21 through 3-23.

In short, the recommended one-time grant is an act of belated equity to the RUI system. It would assist the RUI system in recovering from the effects of the 1981-83 recession, just as the state UC systems long have been assisted in recovering from the effects of high unemployment through interest-free loans or restrictions upon the interest payable.

Solvency of the revised RUI system. Actuarial predictions of the future can never be certain, but the RUC Committee utilized pessimistic assumptions in regard to future railroad employment so as to minimize the chances of erring on the side of over optimism. Of the three employment assumptions utilized, Assumption I is that employment will decline by an average of 1% per year through the year 2000 (from 400,000 in 1984 to 340,000 in 2000); Assumption II posits an average decline of 3% per year (from 400,000 in 1984 to 242,800 in 2000); and Assumption III posits an average decline of 5% (from 400,000 in 1984 to 176,000 in 2000). All three assumptions have built-in periods of recession and recovery which, while necessarily arbitrary as to timing and extent, are more realistic for purposes of estimating the costs of unemployment benefits than assuming a level rate of decline over a period of 15 years. Other assumptions, including interest rates, are based upon OMB's economic assumptions. See Report, App. E, p. ii and Tables A-I, A-II and A-III.

The RUC Committee concluded that "the 'most likely' estimate is somewhere between Employment Assumptions I and II." Nonetheless, the Committee assured itself that the consensus package would restore and preserve the financial solvency of the RUI system through the year 2000 under Employment Assumption III, as well as under Assumptions I and II, even though it pointed out that Assumption III is "unduly pessimistic" and regarded Assumption II as the most prudent assumption. See Report at 3-30, and App. F. Hence, there is every reasonable prospect that enactment of the entire consensus package will fully restore and preserve the solvency of the RUI system.

THE ADMINISTRATION'S PROPOSAL FOR COVERAGE OF THE RAILROAD INDUSTRY BY THE FEDERAL-STATE UC SYSTEM

In testifying on May 3, 1983 before the Subcommittee on Public Assistance and Unemployment Compensation of the House Ways and Means

Committee, in regard to proposed legislation that eventuated in the Railroad Retirement Solvency Act of 1983, former OMB Director David Stockman expressed concern that continuation of the RUI system might necessitate additional unemployment taxes which would "end up doing a fairly severe damage to the [railroad] industry," and further testified that:

> "Well, as I said, there is nothing wrong in principle with full financing of the existing system with an adequate tax rate. But as I looked at the tax rate that would be necessary to finance the existing rail UI system, I concluded that a phased merger with the Federal/State system is more reasonable in terms of the economic burden on the industry."

(Hearings on the Railroad Solvency Act of 1983: Retirement and Unemployment Insurance Issues, at 304, 307-08.)

As we have demonstrated, the consensus package recommended by the RUC Committee would result in a continued RUI system supported by "an adequate tax rate" that clearly would be "more reasonable in terms of the economic burden on the industry" than would even the most favorable program yet devised for bringing the railroad industry under the coverage of the federal-state UC system. But however that may be, OMB on behalf of the Administration apparently will propose legislation that would cost the railroad industry an estimated $1.6 billion more in the 1986-2000 period than would the consensus package. If such legislation should be enacted, it would indeed "end up doing a fairly severe damage to the" railroad industry.

Even before the RUC Committee issued its final Report, the Administration transmitted to the Congress proposed "Railroad Unemployment

Compensation Amendments of 1984" which apparently were intended to implement a proposal by OMB in the FY 1985 budget for transfer of the railroad industry to the coverage of the federal-state UC system. While we were disappointed that the Administration did not await the Report of the RUC Committee before drafting proposed legislation, this did afford the Committee an opportunity to evaluate the legislation as drafted by the Administration. The Committee "considered that Administration bill, as well as the presentation made by OMB, and . . . unanimously concluded that its enactment should not be recommended to the Congress." Report at 5-1.

The "labor members strongly oppose[d] termination of the independent RUI system either as proposed in the Administration bill or otherwise" (Report at 5-1; see, also, pp. 6-1 through 6-3), and the Chairman "agree[d] with the management members that," for reasons set forth on pages 5-2 through 5-4 of the Report, "the Administration bill would not provide an equitable transition and cannot be recommended to the Congress even assuming that, in principle, the railroad industry should be brought within the coverage of the federal/state UI system." Report at 5-2.

While that Administration bill (subsequently introduced as H.R. 6068) was technically defective in many respects, some of which were pointed out in Appendix H to the Report of the RUC Committee, its fundamental defect was the completely unreasonable unemployment tax burden that would have been imposed upon the railroads. The entire financial burden of the transition would have been placed upon the railroads, and for several years extending into the 1990s they would have been required to pay both the federal-state unemployment taxes and full RUI unemployment taxes (including the Repayment Tax enacted by the Solvency Act of 1983). See Report at 5-3 and 5-4. It "plainly would be unreasonable to burden the railroads for several years with unemployment taxes approximately double those now paid and far in excess of those paid by employers in other industries including competitors of the railroads." Report at 5-4.

The one feature of that Administration bill which could be said to be favorable to the position of the railroads was that it would have assured that the railroads initially would be treated as new employers by the state UC systems, until covered by those systems long enough to have their tax rate determined through experience rating (generally, after one to three full years or more of coverage). While that would have been a "favor" only in that it would assure that the railroads would be treated in the same manner as other employers when first subjected to coverage by a state UC system (regardless of how long that employer may have been in existence), most state systems provide a relatively low "new employer" tax rate pending experience rating.

However, a draft bill transmitted to the Congress by the Secretary of Labor on May 22, 1985 (but not yet introduced, insofar as we are aware) indicates that the Administration now proposes to deprive the railroads of even that solitary favorable feature. The states would be afforded an option to require a railroad, through 1988, to reimburse the state UC systems for the actual cost of unemployment benefits paid out to the railroad's employees, rather than paying the new employer tax rate during that transition period. Thereafter, the railroad would pay the tax rate imposed by the applicable state law (and FUTA) including experience rating. In effect, therefore a particular state could elect either to apply its new employer rate or to require reimbursement during that transition period, depending upon which is anticipated to produce the most revenue from the railroads that would be covered by the state's law, while the railroads would have no option other than to accept the state's choice.

The bill which has now been produced by the Administration does not even eliminate the technical defects in its prior bill, much less remedy any of the fundamental objections to that prior proposal pointed out in the Report of the RUC Committee. Rather, the Administration would continue to place the entire cost of the transition upon the railroads, as well as increasing that cost insofar as the railroads no longer would be assured of payment of new-employer rates prior to the application of experience rating.

In addition to paying the full cost of unemployment benefits paid by the state UC systems to railroad employees during the transition period (except as a state may elect to apply its unemployment tax, including the new-employer rate, during that period), the railroads would be required to pay: (1) full state and federal unemployment taxes after the transition period, including taxes utilized in repaying borrowings by the state systems (or by the Extended Unemployment Compensation Account) prior to coverage of the railroad industry; (2) the maximum contributions or taxes now required by the RUI Act (_i.e._, 8% of monthly wages up to the $600 maximum, which, however, under the bill would be imposed by the Internal Revenue Code) until all borrowings from the Railroad Retirement Account have been repaid with interest; and (3) the Repayment Tax enacted by the

1983 Solvency Act. In short, as we understand, the Administration continues to propose legislation that would have the effect of imposing unemployment taxes (or their equivalent) upon the railroads that would be approximately double the taxes they now pay for years to come and much more than those paid by employers in other industries including competitors of the railroads. That is at least as unreasonable and unfair today as it was when the RUC Committee issued its Report.

H.R. 3128

H.R. 3128, which was favorably reported by the House Ways and Means Committee on July 31, 1985, proposed in general "to make changes in spending and revenue provisions for purposes of deficit reduction and program improvement, consistent with the budget process . . . ." H. Rept. No. 99-241 (Pt. 1) at 1. Title IV of that bill contains "Provisions Relating to Railroad Unemployment Repayment Tax and Unemployment Compensation." Section 401 would revise the Railroad Unemployment Repayment Tax, enacted by Subtitle B, Part I, of the Railroad Retirement Solvency Act of 1983, so as to greatly increase the taxes that would be imposed upon the railroads, for purposes of repaying with interest outstanding borrowings before October 1, 1985 by the RUI Account from the Railroad Retirement Account, and would enact an entirely new tax for repayment of borrowings after September 30, 1985. Section 402 would repeal a sentence added to § 10(d) of the RUI Act by Sec. 302 of that 1983 Solvency Act which prohibits further borrowings by the RUI Account from the Railroad Retirement Account after September 30, 1985, and thus would restore the borrowing authority that heretofore has existed. No other revisions of the RUI system are proposed.*/

We have no fundamental objection to the restoration of the RUI Account's authority to borrow from the Railroad Retirement Account. Some kind of borrowing authority is essential to a properly functioning unemployment compensation system so that unemployment taxes and benefits can be maintained on a relatively even keel despite temporary swings in the unemployment rate. We believe that, as recommended by the RUC Commission, the general fund is a more appropriate source for such borrowings since it is the ultimate source of borrowings by the state UC systems. More importantly, we do not see any justification for depriving the RUI system of the benefit of restrictions upon interest payable upon its borrowings comparable to the restrictions imposed upon the interest payable by the state systems upon their borrowings. By omitting such restrictions, contrary to the recommendations of the RUC Committee, Sec. 402 of H.R. 3128 would perpetuate into the future the very kind of inequity that, as imposed in the past, justified the recommendation by the RUC Committee for a one-time $135 million federal grant to the RUI system. While we recognize that the budget deficit is a real problem insofar as such a grant is concerned, however much it otherwise may be justified, surely that cannot be an adequate justification for perpetuating into the future the underlying discrimination against the RUI system.

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*/ Sec. 403, the only other provision in Title IV of H.R. 3128, proposes a minor change in the Federal Supplemental Compensation program so as to allow "certain unemployed individuals in the State of Pennsylvania to collect the remainder of their FSC benefits, notwithstanding the requirement of P.L. 99-15 that such benefits be collected in consecutive weeks," where the collection of such benefits "was interrupted . . . when they were called up in the National Guard in early June to provide services during a major disaster in the State . . . ." H. Rept. No. 99-241 (Pt. 1) at 72.

We object strongly to the proposed revision of the Repayment Tax, and particularly to its provision of substantial unemployment tax increases without any provision for the restructuring of the RUI system recommended by the RUC Committee or any assurance that such a balanced program for restoring the solvency of the RUI system will be thoroughly considered. As enacted by the 1983 Solvency Act, the Repayment Tax would be imposed upon the railroads at the rate of 2% for the last months of 1986, 2.3% for 1987, 2.6% for 1988, 2.9% for 1989, and 3.2% for the first nine months of 1990 before terminatng on September 30, 1990. Those tax rates would be applied to "wages" essentially as defined in FUTA up to an annual maximum of $7,000 ($3,500 for the last six months of 1986 and $5,250 for the first nine months of 1990). Under Sec. 401 of H.R. 3128, those tax rates would be substantially increased in 1986-88, so as to become 4.3% for the last six months of 1986, 4.7% for 1987, 6% for 1988, 2.9% for 1989, and 3.2% for the first nine months of 1990 when what would be designated as the "basic rate" would terminate. In addition, a separate "surtax rate" of 3.5% would be imposed on the railroads in any calendar year (including years after 1990) after a September 30 on which there is an outstanding debt owed by the RUI Account to the Railroad Retirement Account on borrowings made after September 30, 1985.

Both the basic rate and the surtax rate, if applicable, would be applied to "compensation" as defined in the Railroad Retirement Tax Act up to an annual maximum of $7,000 ($3,500 for the last six months of 1986, and

$5,250 for the first nine months of 1990 with respect to the basic rate). We approve of the proposed substitution of "compensation" as thus defined for "wages" essentially as defined in FUTA. Although it seems to us more logical to utilize "compensation" as defined in the RUI Act rather than as defined in the RRTA, those definitions are virtually identical (apart from the maximums) and either should suffice to avoid the administrative difficulties and expense that would be entailed if the railroads should be required to familiarize themselves with and otherwise adapt to FUTA's definition of "wages." Our approval does not, however, extend to other aspects of the tax increases thus proposed.

The revenues from the proposed basic tax would be "credited against, and operate to reduce, the outstanding balance of railroad unemployment loans made before October 1, 1985" (lines 21-23 on page 142 of H.R. 3128) with any surplus after full repayment being deposited in the RUI Account. We assume that the "outstanding balance" thus referred to would include both the principal of and interest on those pre-October 1, 1985 loans, including any interest that may accrue on or after October 1, 1985. H. Rept. No. 99-241 (Pt. 1), at 71, states that "the outstanding debt to the retirement account" as of September 30, 1985 "is estimated to be $783 million, of which $526 million is principal and $257 million is accumulated interest," and there is no provision in H.R. 3128 either for forgiveness of interest as recommended by the RUC Committee or for diversion of a portion of the revenues from tier 2 railroad retirement taxes as is recommended by the Railroad Retirement Board as we have described above.

The revenues from the proposed surtax would be "credited against, and operate to reduce, the outstanding balance of railroad unemployment loans made after September 30, 1985" (lines 5-7 on page 143 of H.R. 3128) with any surplus after such repayment being deposited in the RUI Account. That surtax in itself is similar to a 3.5% surtax recommended by the RUC Committee in the event that outstanding borrowings have not been repaid. However, the surtax so recommended would have been in addition to normal taxes or contributions that would be determined through experience rating and the proposed repayment tax would have been limited to a rate that, on a level basis as adjusted from time to time, would have repaid the principal of the pre-October 1, 1985 loans by the end of the year 2000. H.R. 3128, on the other hand, not only would impose a much higher "basic" repayment tax rate (although over a shorter period), but also omits experience rating as well as other recommendations by the RUC Committee. Hence, the surtax would be imposed upon top of the maximum 8% normal contribution rate now payable by all railroads under § 8 of the RUI Act and in addition to the basic repayment tax as explained above.

While dedication of the revenues from the basic repayment tax to payment of the principal and interest on borrowings prior to October 1, 1985 implies that the revenues from normal contributions are intended to be used exclusively for the payment of benefits on and after that date, there is nothing in the proposed statutory language that so provides and prevents the diversion of a portion of those revenues to repayment of the pre-October 1, 1985 debt. If that should be done it virtually would assure that the normal tax or contribution rate will remain at the 8% maximum until that debt is fully repaid, and would greatly enhance the possibility that the 3.5% surtax rate will be triggered since no surplus could be built up to help avoid the necessity of post-September 30, 1985 borrowings. Moreover, use of the revenues from normal contributions for that purpose would be incompatible with experience rating since in effect it would import an element of cost incurred before experience rating commenced.

In short, H.R. 3128 apparently contemplates that both the principal and interest of the pre-October 1, 1985 debt would be paid out of increased unemployment taxes imposed upon the railroads. This would be done despite the facts that the Railroad Retirement Account has a surplus that could be used (in the form either of a forgiveness of interest or of a diversion of a portion of tier 2 tax revenues) to lessen the increased tax burden that would be imposed upon the railroads without endangering the solvency of the railroad retirement system, that the funds in the Railroad Retirement Account also come from employment taxes paid by the railroad industry and no other taxpayers would be affected, that the RUC Committee has recommended interest forgiveness and the Railroad Retirement Board has recommended the diversion approach, and that both the railroads and the unions representing their employees support either such use of surplus funds in the Railroad Retirement Account. There is no explanation in H. Rept. No. 99-241 as to why the Ways and Means Committee ignored or rejected those considerations. In our view, those factors compellingly call for either interest forgiveness or a diversion of a portion of tier 2 tax revenues as has thus been recommended. It is imperative that this Committee and the Congress so conclude if the unemployment tax burden imposed upon the railroads is to be kept within anything like reasonable bounds.

Indeed, if Title IV of H.R. 3128 should be enacted intact, the railroads could be subjected in 1988 to a combined unemployment tax rate amounting to an astounding 17.5% of taxable payroll (the 8% normal maximum contribution rate, plus the 6% basic repayment tax and the 3.5% repayment surtax). Although the potential combined maximum would be somewhat less both before and after 1988 because of the variations in the rate of the proposed basic repayment tax, the underlying problems of the RUI system will not have been resolved. The estimated $522 million in revenues from the proposed basic repayment tax would not nearly suffice to repay the principal and interest of the pre-October 30, 1985 debt, and thus that debt could continue to burden the RUI system for years to come after September 30, 1990, perhaps extending beyond the year 2000. Moreover, it defies common sense to expect that benefits will remain at their present $25 per day level until the year 2000 or beyond. Hence, the stage could be set for further unemployment tax increases in later years over and beyond those proposed in H.R. 3128.

That is only one part of our concern that H.R. 3128 endangers the entire program for restoring and preserving the solvency of the RUI system recommended by the RUC Committee, even apart from its clear departure from the tax aspects of those recommendations. Although a subcommittee of the House Energy and Commerce Committee has held hearings on those recommendations, a bill has not yet been reported, and the Senate Committee on Labor and Human Resources has yet to schedule hearings. Separate consideration and enactment by the Congress of unemployment tax legislation almost certainly would enhance the possibility that benefits legislation will be a victim of the press of business before the Congress, as well as making more difficult the enactment of a balanced program such as was recommended by the RUC Committee even if benefits legislation eventually is considered and enacted. The best opportunity for a rational restructuring of the entire RUI system will have been lost, and the entire burden of restoring its solvency will be placed upon the railroads. This not only would be highly unfair to the railroads, it also would not be in the best interest of their employees and, we submit, would be contrary to the public interest.

There is one other aspect of H.R. 3128 that we will take this opportunity briefly to discuss since, while not directly related to the RUI system, it would adversely affect the railroad retirement system. That is the provision in Sec. 504 of the bill which would subject a portion of tier 1 railroad retirement benefits to the income taxes applicable to tier 2 railroad retirement benefits and to private pensions, rather than to the income taxes now applicable to all tier 1 benefits and to social security benefits. The result would be to increase the income taxes payable by some railroad retirement beneficiaries, and to decrease the tax revenues dedicated to the funding of railroad retirement benefits.

Tier 1 railroad retirement benefits generally are equivalent to the benefits that the social security system would pay if applicable to railroad employment. However, there are some differences in the qualifying requirements of the two systems so there are some circumstances in which one system pays a benefit amount which the other would not pay. While no credit would be given in respect to those circumstances in which social security would pay a benefit amount that tier 1 of railroad retirement does not pay, those tier 1 benefit amounts that are payable in circumstances where social security would not pay a benefit would be taxed under Sec. 504 as if a tier 2 benefit. The principal such circumstances involve early retirees since railroad retirement permits retirement upon attaining age 60 while social security requires attaining age 62, and disability beneficiaries since railroad employees may be eligible for disability benefits if disabled for work in their regular railroad occupation even if not disabled for all work as is required by social security.

Revenues from the income tax on tier 1 benefits are payable into the Railroad Retirement Account, while revenues from the income tax on tier 2 benefits are payable into the Railroad Retirement Account only through FY 1988 up to an $877 million cap and thereafter (or above the cap) are payable into the general fund of the Treasury. Thus, enactment of Sec. 504 not only would increase the income taxes payable by some early or disability railroad retirees, but also would decrease the funding of the Railroad Retirement Account at least after the end of FY 1988. Moreover, those tax provisions were a significant part of a carefully crafted series of compromises enacted by the Railroad Retirement Solvency Act of 1983 with the support of railroad management, railroad labor, and the Administration through OMB. The enactment of Sec. 504 of H.R. 3128 would upset the premises upon which railroad management and labor supported that legislation, and which were accepted by OMB and approved by the Congress only two years ago. Consequently, we oppose enactment of that provision.

CONCLUSION

The railroads believe that continuation of the RUI system as revised in accordance with the consensus recommendations of the RUC Committee represents the best of the available alternatives for resolving the financial problems of that system. While such legislation would impose a substantial additional tax burden upon the railroads, the costs of restoring the financial solvency of the RUI system also would be shared, in part, with railroad employees and with the federal government (to the extent of the one-time $135 million grant), and the system would be restructured so as to provide a well-balanced program of taxes and benefits for years to come. Consequently, the railroads fully support enactment of the consensus recommendations by the RUC Committee (although we accept diversion of a portion of tier 2 railroad retirement tax revenues as an alternative to a set aside of the interest on the pre-October 1, 1985 debt). The railroads adamantly oppose the Administration's proposed transition to coverage of the railroad industry by the federal-state unemployment compensation system. The railroads also are opposed to H.R. 3128 insofar as it would increase unemployment taxes payable by the railroads without enacting the basic reforms of the RUI system recommended by the RUC Committee, and insofar as it would adversely revise an aspect of the taxation of railroad retirement benefits agreed to only two years ago.

STATEMENT OF MR. RICHARD I. KILROY, INTERNATIONAL PRESIDENT, BROTHERHOOD OF RAILWAY AND AIRLINE CLERKS, ROCKVILLE, MD

The CHAIRMAN. Mr. Kilroy.

Mr. KILROY. Thank you, Mr. Chairman.

I won't go into too much detail. The report has been in the hands of the committee, of course, for over 1 year and statements are put into the record.

I want to join my colleagues on the management side in thanking Dr. Myers for his contributions and valuable contributions in assisting us in reaching the conclusions that we did, which is known as a concensus report.

Our system worked, as we have stated—the railroad unemployment system worked for some 46 years. Now, of course, it was 42 years when we first started taking looks at it. And there were no significant problems that could not have been handled; were not handled during that period.

But the basic problem came about because of an unemployment drop of roughly 25 percent the latter part of 1981 and in all of 1982. No system of any unemployment system could have withstood such a shock.

The rail industry, both labor and management, have agreed on a solution, and a solution that we met together with, together with Dr. Myers, and gave or took all through it and reached a solution that would prevent any such happening in the future. And made adjustments and sacrifices from all sides to reach a concensus.

The House Committee has looked at it. And, unfortunately, is treating one part of it, but not all of it. They have not reached permanent solutions to it.

We are glad that at worst they have said they will keep the system. That has been rail labor's position from the beginning, that we wanted to keep the present system.

We certainly are very clear in our opposition to the administration's proposal to shift the railroad unemployment system to the Federal-State plan for the reasons that we have stated in our report.

We think that our system is better in the long run. It handles both railroad—all of railroad retirement, our sickness benefits, and our unemployment benefits. All handled by one agency.

And we oppose a shifting part of that over to the States or the Federal-State plan. And I might add, Mr. Chairman, the States don't want it either, as you may well know.

So, we emphasize, too, that immediate action is necessary because of the fact that as of the last day of September the borrowing authority ceases under existing law and benefits would be cut. And those benefits would adversely affect the working people, working men and women in the railroad, severely. And to the extent in many cases, we have supplemental programs whereby under job protection agreements they are supplemental to railroad unemployment, and they would do serious damage to those agreements.

In addition to that statement, I also want to add to this testimony, while it deals with another subject also on the docket, and that is our opposition to H.R. 3128, as it it involves the taxation of tier 1 component benefits of railroad retirement.

We sent a telegram, Mr. Chairman, to all members of this committee yesterday setting forth our position. I want to reiterate labor's opposition to the taxing of those retirement benefits as outlined by my colleague, Mr. Dempsey.

And I thank you very much for your time. I'll be glad to answer any questions you have.

The CHAIRMAN. Thank you.

[The prepared written statement of Mr. Kilroy follows:]

BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE

TESTIMONY OF THE LABOR MEMBERS OF THE RAILROAD UNEMPLOYMENT COMPENSATION COMMITTEE

SEPTEMBER 13, 1985

As representatives of Railroad Labor on the Railroad Unemployment Compensation Committee established by Section 504 of the Railroad Retirement Solvency Act of 1983, Public Law 98-76, Richard I. Kilroy, International President, Brotherhood of Railway and Airline Clerks, and John F. Sytsma, President of the Brotherhood of Locomotive Engineers, submit the following comments and statement of position:

We do not intend in this statement to detail the history of the Railroad Unemployment Insurance system, the events leading to the enactment of Section 504 of the Railroad Retirement Solvency Act of 1983, or the creation of the Railroad Unemployment Compensation Committee on which we have had the honor to serve.

We, as the appointed representatives of the Railway Labor Executives' Association, rather wish to emphasize to this Committee and to the Congress that the Railroad Unemployment Compensation system now in effect worked in a completely successful manner from 1939 to 1981, notwithstanding all the severe reductions in railroad employment after World War II as the work force in our industry shrank from more than 1.6 million employees to less than 550,000 in 1980. It continued to work successfully until incredibly precipitous reductions in employment occurred in the railroad industry between July 1, 1981, and January 1, 1983, when the number of employees was reduced from 514,000 to 388,000, a drop of 25% in 18 months. No system of unemployment compensation could have withstood that strain.

The numbers of unemployed in the industry became just too great over too short a period of time, and the system could not meet their just demands. A severe problem was created for which a solution had to be found.

At the direction of Congress and with the invaluable assistance of the Chairman and Public Member of the Railroad Unemployment Compensation Committee, Dr. Robert J. Myers, and the members and staff of the Railroad Retirement Board, the Committee found a workable and equitable solution to the problems facing Railroad Unemployment Insurance. That solution, which requires sacrifices from all involved, was set forth in the June 29, 1984 Report of the Railroad Unemployment Compensation Committee. All members of the Committee endorse and recommend that solution which we refer to as the "Consensus package" of the Report.

The Report of the RUC Committee recommended the retention of the present system with certain specified modifications. All members of the RUC Committee were, and are, in agreement that the present system, modified as proposed in their Report, would be fair and would work.

The RUC Committee was also unanimous in its recommendation to this Committee and to the Congress to reject the proposal submitted by the Administration as a solution to the problem confronting us. We understand we are not alone in our opposition to the Administration's proposal or, indeed, any proposal seeking adoption of a Federal/State system of unemployment compensation for railroad employees. We are informed that many individual states have expressed serious concern with having the railroad industry's employment problems added to the enormous difficulties under which their employment systems now labor. In addition, the National Conference of State Legislatures recently rejected the Administration's proposal by formal resolution.

From the railroad employee's point of view we believe the Administration's, or a similar proposal, would be exceedingly inequitable as it would eradicate a system which with one exception covering a few months and caused by an aberrant reduction in employment has worked well for over 45 years; it would be applicable to fewer employees for shorter periods of time; would place enormous additional financial burdens on the industry which ultimately would be paid for by the employees and shippers; and, is not necessary to a solution of the problem caused by the unique employment drop of 1981-1983.

The modified Railroad Unemployment Compensation system presented in the "consensus package" of the Report of the RUC Committee is the result of painful and painstaking efforts by all members of the Committee. It now has the unqualified endorsement of the Chairman of this Committee and each of its members. It preserves for the railroad employees the unemployment compensation system that they have enjoyed for nearly half a century. We are convinced that no sound argument can now be made for destroying that system in favor of a Federal/State system for railroad unemployment compensation.

We appreciate the difficulties faced by this Committee and the Congress in its efforts to reduce the Budget Deficit. We are aware of problems presented by the RUC Committee recommending the forgiveness of interest on the debt owed the Railroad Retirement Account by the RUI account and the grant of $135 million provided for in Report to place the railroads on an equal footing with the state employers regarding interest on loans required to fund unemployment compensation. A proposal has been made to resolve these problems by diverting up to 1% of Tier II Retirement tax to pay the interest on the debt to the Railroad Retirement Account. We are informed that this proposal, if approved, would enable the complete repayment of the debt and all interest well before the year 2000. The RLEA would not oppose approval of such a proposal.

This Committee is familiar with the action taken by the House of Representatives on the subject of railroad unemployment compensation. The Committee on Ways and Means addressed the revenue side of the issue but did not address the benefit aspects which are to be considered by the Energy and Commerce Committee.

As we understand the House's action, it is not intended to be a comprehensive and permanent solution to the problem. It would preserve the system in its present form. It would provide continued authority to borrow from the Railroad Retirement Account and require a surtax of 3 1/2 percent on such borrowed money. If the industry is forced to borrow from that source that surtax may be transformed into a permanent tax. We do not know as yet what the Energy and Commerce Committee may do with the benefits under the Act in light of the House's earlier action.

While we applaud the House's decision to retain the system in its present form, we would have much preferred the enactment of a comprehensive package which would have looked to an overall solution to the problem for the foreseeable future. That is objective and, we believe, the accomplishment of the so-called "consensus package" in the Railroad Unemployment Compensation Committee Report.

There have also been presented to the Congress a number of other proposals dealing with this subject, some of which would raise employee benefits under the Act. While we clearly desire to increase the benefits so dearly earned by our members, we are concerned that the increased costs to the industry of such benefits ultimately will be paid for by employees in other areas. Increases in benefits which eventually may be paid for by the employees themselves must be carefully scrutinized.

In summary, we wish to emphasize our support for the recommendations of the Committee which the Congress created to seek a solution to the vexing problem of railroad unemployment compensation. We believe, on the basis of the evidence available during our consideration of the problem as well as that which has since been developed, that those recommendations in the form presented in the consensus package constitute the fairest, most complete and most long-range solution to the railroad unemployment compensation that is to be found, at least to this point in time.

For the foregoing reasons, we respectfully urge your favorable consideration of the Report of the RUC Committee and the enactment by Congress of a bill that embodies those recommendations of the Report which are viewed by all of its members as financially viable, fair to all and administratively workable.

SUMMARY OF STATEMENT BY ROBERT J. MYERS PRESENTED TO THE COMMITTEE ON FINANCE, UNITED STATES SENATE, SEPTEMBER 13, 1985, WITH REGARD TO THE RAILROAD UNEMPLOYMENT INSURANCE PROGRAM.

The various recommendations in the consensus package developed by the Railroad Unemployment Compensation Committee (established by Section 504 of the Railroad Unemployment Solvency Act of 1983) are described. These are a well-rounded package of changes affecting all parties involved -- railroad workers, unemployment beneficiaries, railroad employers, and the federal government. All parties would play a role in the solution to the financing problem of RUI, both that which has occurred to date and what difficulties may arise in the future. At the same time, the benefit and financing structure is changed so as to be automatically adjusted according to variations in the economy, just as is done under the Social Security program.

Also discussed is a proposal that was made to repay the loan of the RUI Account from the Railroad Retirement Account by moving part of the RR taxes to RUI and then immediately moving them back against as payments on the loan. In my opinion, this is really no different than our direct approach of forgiving a portion of the loan (namely, the interest thereon), except that it is done in a hidden, indirect, and less definite manner.

The experience of RUI since 1983 has been quite favorable -- much more so than was anticipated under the intermediate estimate which we used in drawing up our proposal -- and, of course, much more favorable than the pessimistic assumptions which we used.

Finally, comments are made about the provisions on RUI contained in H.R. 3128, a bill which has been reported out by the House Committee on Ways and Means, but has not yet been acted upon by the full House. That bill, although resulting in the ongoing financial viability of the RUI system by providing for the possibility of loans from the RR Account after September 30, does not solve the financing problems as to the past accumulated debt, let alone making appropriate benefit changes.

STATEMENT OF DR. ROBERT J. MYERS, CHAIRMAN, RAILROAD UNEMPLOYMENT COMPENSATION COMMITTEE, SILVER SPRING, MD

The **Chairman**. Dr. Myers, good to have you with us again.

Dr. **Myers**. Thank you, Mr. Chairman.

As my colleagues, the two previous witnesses, have stated, the Railroad Unemployment Compensation Committee was formed as a result of the serious financial situation facing the railroad unemployment insurance system.

We worked on this matter very extensively and submitted a report somewhat more than 1 year ago.

Our first question was whether the system should continue as an independent one, or whether it should be under the Federal-State system. The two labor members believed very strongly that it should be an independent system. I saw certain advantages of going with the Federal-State system, but I believed that, very clearly in balance, the best method of procedure would be to leave the program as an independent one.

The management members were somewhat more sympathetic to the Federal-State system approach. But, in the end, they joined with the rest of us on the committee to go along with the so-called consensus package of keeping the system as an independent one.

I believe that it is fair to say that this consensus package represents a good balance of sharing the cost, or you might say the pain, among the various parties involved—the railroad workers, the railroad management, and, in part, the General Fund of the Treasury—so as to have a good balance.

This is somewhat the same approach as was done—I think, quite successfully—with the Social Security system in the 1983 reform legislation.

In my testimony, I go into some detail—as our report does even more so—about the various portions of the package. But let me touch on just a few of the more important ones.

First, there would be the forgiveness of interest on the loans that were made from the railroad retirement account in the past 3 or 4 years to railroad unemployment insurance to keep it going. That interest being at the very high rates that have been applicable in the past, and even currently, has been overwhelming to the RUI system.

We believe that forgiving the interest is not something that is going to hurt the general taxpayer. It would not really hurt the railroad retirement system either, because its financing was based on the assumption that the interest would not be repaid, and, in fact, that not even all of the principal would be repaid. So, this forgiveness was really within the railroad industry and its workers—by shifting the cost partly from one system to the other.

Our proposal also went much further than present law by assuring that there would be a repayment tax which, over roughly the next 15 years, would repay the entire principal of the loan. And present law, I emphasize, will not do that.

We also made recommendations for changes in the benefit provisions. There were a number of restrictions that railroad labor agreed to in the interest of cutting down the cost of the system.

But, also, there were certain proposals to keep up the program to date—or rather some might say to liberalize the system—by increasing by a small amount the daily benefit rate, but at the same time providing for meeting this cost by also automatically adjusting the taxable earnings base, just as is done under Social Security.

Our package also provides for experience rating, so that instead of all employers paying the same rate, there would be a varying rate—as in the state systems—so that employers with good records would have lower rates, and employers with poor records would have higher rates. This might help, to some extent, to cut down on unemployment.

We also provided that there would be a general surcharge tax rate if the fund balance got very low, so as to prevent any future serious financial difficulties. Or if the fund got very high, there would be a general credit against the tax rate.

We further recommended that there should be a Federal grant to represent past inequitable treatment of the railroad unemployment insurance account by the general fund. And, again, something similar to this was done in the Social Security reform package; there were certain federal grants made so as to make up for certain past inequitable treatment.

Next, I should like to refer to a proposal that the Railroad Retirement Board has made recently—that there should be a diversion from the railroad retirement tax rate to the railroad unemployment insurance rate. I think this would do the job of maintaining the program. However, I don't particularly favor it. I think it really, in essence, would not only waive the interest, but also the principal of the debt.

H.R. 3128 has certain merit in that, at least, the system will continue beyond September 30, but it is really a patchwork job. I would urge the committee to consider what I believe is a well-rounded, balanced package—that which our committee developed and recommends for your consideration.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Myers.

[The prepared written statement of Dr. Myers follows:]

STATEMENT BY ROBERT J. MYERS PRESENTED TO THE COMMITTEE ON FINANCE, UNITED STATES SENATE, SEPTEMBER 13, 1985, WITH REGARD TO THE RAILROAD UNEMPLOYMENT INSURANCE PROGRAM.

Mr. Chairman and Members of the Committee: My name is Robert J. Myers. I served in various actuarial capacities with the Social Security Administration and its predecessor agencies during 1934-70, being Chief Actuary for the last 23 of those years. In 1981-82, I was Deputy Commissioner of Social Security, and in 1982-83, I was Executive Director of the National Commission on Social Security Reform.

Section 504 of the Railroad Retirement Solvency Act of 1983 established the Railroad Unemployment Compensation Committee, which was assigned the responsibility of reviewing all aspects of the unemployment and sickness benefit system provided for by the Railroad Unemployment Insurance Act, in the light of its financing problems. In December 1983, the two representatives of railroad labor and the two representatives of railroad management on the Railroad Unemployment Compensation Committee requested me to be the public member.

The Report of the Committee was submitted on June 29, 1984. As with any consensus agreement, none of the members of our Committee are enthusiastic about all of the recommendations made. However, we agreed that, under the circumstances, the consensus agreement is the best method to achieve long-range financial solvency for the program if it is to remain an independent one.

The first problem facing the Committee was whether RUI should continue as an independent system, or whether it should, in some manner or other, be merged with the federal/state system. The two labor members believed very strongly that RUI should continue as an independent system and, in balance, I too believed that this was the better approach. The two management members strongly preferred a merger with the federal/state system if this could be done in an equitable and reasonable manner -- but if not, then they joined with the other Committee members in developing the consensus package under the independent-system approach. All of the members of the Committee believe that the proposal of the Administration for a merger of RUI with the federal/state system, as transmitted by the Secretary of Labor in a draft bill to the Congress on June 4, 1984 should not be enacted.

I had several reasons for preferring to maintain RUI as an independent system. First, I believed that the program had been operating successfully from an administrative standpoint for nearly half a century, and I did not see sufficient reasons to alter the situation. Second, I saw advantages in having all of the federally-legislated employee benefits for the railroad industry -- retirement, disability, survivor, sickness, and unemployment -- being administered by one government agency. Third, I saw great potential difficulties -- if not impossibilities -- in developing a reasonable and equitable transition from an independent system to the federal/state system.

Despite my strong preference for the independent-system approach, I did work with the two management members to develop the best possible method of merging RUI with the federal/state system, if this were to be done.

In concluding, I shall list the several recommendations in the consensus package for a continued independent RUI system. Several of these recommendations are also contained in the proposal of the two management members for a merger of RUI with the federal/state system, and I believe that they will describe that proposal in detail in their testimony. The 14 recommendations in the consensus package are as follows:

(1) The accrued interest on loans from the Railroad Retirement Account would not be repaid, although the full principal would be. It should be noted that this involves, in essence, only financial transactions within the railroad industry and its employees, and it does not represent any cost at all to the federal government or the general taxpayer.

(2) The present loan-repayment tax should be replaced by a similar tax at a level rate that, after adjustment every 3 years, will fully pay off the principal by the year 2000. This represents a distinct improvement over present law, where the repayment tax does not even take care of the outstanding principal, let alone any interest thereon. The financing of the Railroad Retirement system is not founded on receiving any more from RUI than the proceeds from the present repayment tax.

(3) The maximum taxable earnings base should be indexed by 2/3 of the rate of increase in the nationwide wage level. This is a distinct improvement over the past situation where the base remained constant -- and thus relatively deteriorated -- for long periods of years.

(4) The tax rate should be experience rated for each employer. This follows the procedure under the state systems and will encourage employers to stabilize employment.

(5) A surcharge tax rate should be provided when the fund balance is low. Similarly, when the fund balance is very large, a flat tax-rate credit would be given. This serves as a stabilizing and, to a considerable extent, fail-safe device.

(6) The bands in the schedule determining the surcharge tax rate should be indexed for increases in the total taxable payroll. This is desirable so as to recognize changes in economic conditions.

(7) The allocation for administrative expenses should be increased slightly, to an appropriate level. The administrative costs of the system have been reasonable, but the long-time freezing of the earnings base made the previous allocation rate insufficient.

(8) Advance quarterly tax transfers should be made, repayable with interest. This is the same procedure as is provided to the Social Security trust funds as a result of the Social Security Amendments of 1983.

(9) A grant of $135 million should be made by the General Fund. This will equalize for past preferential treatment given to the state systems, primarily through direct or indirect interest-free loans.

(10) The RUI account should be able to borrow from the General Fund, repayable with appropriate interest. It seems only fair to give RUI the same treatment as the state systems have. As discussed later, the Committe believes that, even under very pessimistic future conditions, such borrowing will not likely be necessary, or at most will be of only relatively small size, with repayment quickly.

(11) The maximum daily benefit rate should be increased from the present $25 to $27, and later should be indexed in approximately the same manner as the maximum taxable earnings base. It seems desirable, just as in the case of the earnings base, that some automatic adjustment should be made in the future, so as to reflect changes in economic conditions in the country.

(12) *Qualifying conditions should be made stricter by requiring covered wages in a year to be at least 5 times the monthly maximum base subject to tax, and by requiring actual service in at least six months of such year.* This change is made to reduce the cost of the program and to prevent benefits being payable for much longer than the period of actual employment.

(13) *Benefits should be payable for a maximum of 7 days (instead of the present 10 days) in the first 14-day registration period in each benefit year.* At present there is, in essence, no waiting period, and this proposal would reduce costs by establishing approximately a ½-week waiting period.

(14) *Employers should be given more possibility of participating in claims actions, but not so as to prevent timely payment of benefits.* Such procedures are effective in the state systems, and they especially seem necessary if there is to be experience rating.

The consensus package was developed so as to make the RUI system financially viable under pessimistic employment assumptions. The provision for loans from the General Fund would not be utilized in the next 15 years under these assumptions, except under the very most pessimistic set, under which small loans would be needed in 1987-88, but would be repaid in 1989. Even if the experience is worse than in the most pessimistic estimate, repayment of the loans could readily be made in a very few years as a result of the recommended surcharge tax rate. In summary then, I believe that the consensus package is a financially responsible and equitable one that will restore the RUI system to solvency and maintain it over the years.

Subsequent to the release of the Report of the Committee -- at hearings before the Subcommittee on Commerce, Transportation and Tourism of the House Committee on Energy and Commerce on April 3, 1985 -- the management members modified their views and came out completely in favor of the consensus package. They did so on the grounds that it seemed impossible to develop an equitable and reasonable transition to the federal/state system.

Another approach for solving the impending financial crisis of RUI was given in the Sixteenth Actuarial Valuation Report of the Railroad Retirement System. In accordance with the requirements of Section 502 of the Railroad Retirement Solvency Act of 1983, the report recommended, with regard to RR taxes, that "It is feasible to divert a portion of employer taxes to the Railroad Unemployment Insurance Account to aid in the repayment of its debt to the Railroad Retirement Account". Specifically, this recommendation was that 1% of tier-2 payroll, starting in 1986, would be so diverted and then immediately returned to the RR Account to repay the loan (including accumulated interest). This 1% diversion would continue until the debt would be repaid -- estimated to occur no later than 1990. Such approach would also be under the conditions that no further loans would be made by the RR Account to the RUI Account after September 30, 1985 and that the temporary (from July 1986 through September 1990) Railroad Unemployment Repayment Tax would continue as provided under present law.

As I see it, the net effect of the foregoing proposal is merely -- by diverting and then immediately returning an amount equal to 1% of tier-2 payroll -- to place the RR Account in no different position than it would be under present law. Thus, the loan from RR to RUI would be said to be paid off in full within about 5 years, but actually the net effect would be that only part of the principal will really, in balance, be paid to RR. Nonetheless, the RR Account has sufficient resources over the long run to be adequately financed under valuation A of the Valuation Report.

Although I see some merit to the foregoing recommendation (which would have to be implemented by other changes in order to assure the solvency of RUI after September 1985), I very much prefer the solution in the consensus package. The latter is a well-rounded combination of benefit and financing changes that treats all parties -- employers and employees, the General Fund, and the RR Account -- reasonably and equitably and has an excellent chance of placing the program on a sound basis over the long range.

- It is significant that the experience of the RUI program since the Railroad Unemployment Compensation Committee began its work has been notably better than was anticipated. Although this does not give complete assurance that the consensus package will solve the financing problems of the RUI system over the long run, it does make this more likely.

Specifically, the actual FY 1984 experience as compared with the estimates therefor presented in our report are as follows for certain key elements (in millions):

Item	Actual Experience	Estimated Experience
Contributions in year	$190	$187
Loans from Railroad Retirement in Year	96	190
Benefit Payments in Year	209	297
Interest on Loan from RR in Year	72	78
Balance at End of Year	-672*	-766
Loan from RR at End of Year	676*	-762

* Adjusted to reflect interest due, but not paid until following month.

Thus, it can be seen that the actual experience was quite favorable. Benefit outgo was about $90 million less than estimated. Accordingly, the needed loan from the Railroad Retirement Account in FY 1984 -- $96 million -- was almost $100 million less than estimated, and the accumulated RR loan at the end of the year was $86 million less than estimated. The actual benefit outgo was only about $20 million less than the tax contributions -- as against an estimated deficit of $110 million. Thus, the continuing overall deficit of the program (and the need for continuing sizable loans from RR) arises from the burden of the interest payments on the debt incurred in the past.

The latest available current experience -- for October 1984 through April 1985 -- shows continuing favorable results. Benefit outgo was running at an annual rate of about $205 million, while contribution income for FY 1985 is anticipated to be about $222 million.

The Committee on Education and Labor and the Committee on Ways and Means of the House of Representatives have held hearings on Railroad Unemployment Insurance. The other members of the Railroad Unemployment Compensation Committee and I testified as to why we believed that our consensus package is equitable to all parties involved and would solve the financing problem of the RUI system.

The only action taken in the House of Representatives before this month has been to include a Title IV, "Provisions Relating to Railroad Unemployment Repayment Tax and Unemployment Compensation" in H.R. 3128, "Deficit Reduction Amendments of 1985". This Title merely (a) permits the RUI Account to borrow from the Railroad Retirement Account after September 30, 1985, but institutes a surtax repayment tax of 3½% when any accumulated loan after such date is present on a September 30, and (b) increases the basic repayment tax (which, under present law, will go into effect on July 1, 1986) through December 1983 over what is now scheduled, but leaves unchanged the rates for January 1989 through September 30, 1990 (when the tax terminates).

I have the highest regard for the House Committee on Ways and Means, but I am constrained to say that its efforts in H.R. 3128 do not, by any means, solve the financing problems of the RUI system. Obviously, by increasing taxes and allowing for further loans, but with a significant surtax repayment tax then being triggered, the situation is improved, but is not fully remedied. Estimates prepared by the Railroad Retirement Board show that, under intermediate economic assumptions, if all yearly excesses of income over outgo are retained in the RUI Account in order to meet deficits in other years (rather than repaying the past loans from the RR Account), the RUI Account will only rarely hve to borrow further from the RR Account, and then, with the surtax rate being triggered, will shortly repay such new loans. However, the past loans from the RR Account will not be repaid by the basic repayment tax; such outstanding balance will decrease during 1989-90, but thereafter it will rise steadily and significantly. Moreover, such results will be much less favorable if pessimistic or unfavorable economic conditions occur.

In contrast, our consensus package does give a balanced, equitable method of dealing with the financing problems of the RUI system over the long run, even if economic conditions are unfavorable. At the same time, it contains certain provisions for updating and keeping current the benefits of the program, while providing the necessary financing therefor. In particular, I believe that our surcharge tax rate when the fund balance is low is far superior to the sudden imposition of such a tax in H.R. 3128 when the fund balance becomes negative (as a result of a loan from the RR Account being necessary). Our procedure gradually phases in such a tax when the fund balance is low, and this could well prevent the fund from being exhausted. In fact, I believe that the phasing in of such rate could well begin somewhat sooner -- e.g., a rate of .5% when the balance is less than $150 million, but more than $100 million.

As a technical point, both present law and H.R. 3128 have an earnings base of $7,000 per year on which the repayment taxes are levied. I suggest that, as a simplification measure, the same base should be used for both the RUI regular and repayment tax rates.

STATEMENT OF MR. JAMES R. SNYDER, CHAIRMAN, LEGISLATIVE COMMITTEE, RAILWAY LABOR EXECUTIVE ASSOCIATION, WASHINGTON, DC

The CHAIRMAN. Mr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

It's my pleasure to be here this morning and appear before the committee on behalf of Mr. Ole Berge, who is the chairman of the Railway Labor Executive Association. I have with me a nice young lady, Ms. Madigan, who is the fill-in for our counsel for the Railway Labor Executive Association.

I appear here today on behalf of all of our active 400,000 railroad employees, as well as approximately 500,000 retirees that are now under tier 1.

Our purpose here, Mr. Chairman, is the administration has recommended the technical conformance amendment dealing with the tier 1 taxation, the remaining people under tier 1. Their explanation of this was that it's a technical conforming amendment.

The railroad retirees—and I'm talking about the 500,000; many of them on disability, a large percentage; widows, and older people—this is nothing but a tax increase.

They are already under tier 1, as you know, paying—because you are drawing two forms of a pension here under tier 1—the taxation formula of Social Security. So, now this would be everything over and above Social Security, which, it is my understanding—the taxation would be on the total amount the same that was applied in 1983 on the career railroad employees.

At that time, our committee members at this table put railroad retirement in a good sound financial state. I was privileged to work with that group and the committees and on the Hill.

The first thing when we sat down to conform with that request was that we were going to get a taxation on Social Security and railroad retirement.

My impressions and a lot of our impressions were that it was going to be practically the same formula applied to Social Security. But it didn't turn out that way. The Social Security—if that had been the case, then certainly we would certainly be along with all the other people.

Our railroad retirement is integrated with Social Security, although the pensions are higher. Over the years we have paid more money into the fund. But now we are talking about the total amount. And the remaining amount of tax that they didn't act on under tier 1 in 1983.

So, I have been advised by the railroad retirement board that if we follow along what the House did and put it in effect—and their recommendation is 3128, effective January 1, 1986—there is no way the railroad retirement board can crank it up and be ready for this additional tax.

Also in the budget—Mr. Chairman, the administration is recommending a 10-percent cut across the board of all railraod retirement board employees. So, we have a serious problem.

But on behalf of all these people, we request you deny this request of the administration on this because we don't think it's a fair tax.

Thank you very much.

The CHAIRMAN. Mr. Snyder, thank you.

[The prepared written statement of Mr. Berge follows:]

BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE

STATEMENT OF THE RAILWAY LABOR EXECUTIVES' ASSOCIATION ON THE PROPOSED TAXATION OF TIER I RAILROAD RETIREMENT BENEFITS

SEPTEMBER 13, 1985

My name is Ole M. Berge. I am Chairman of the Railway Labor Executives' Association and President of the Brotherhood of Maintenance of Way Employes.

The Railway Labor Executives' Association is an unincorporated association with which are affiliated the chief executive officers of all of the standard national and international railway labor unions in the United States. The organizations whose chief executive officers are members of the RLEA are listed below:

American Railway & Airway Supervisors Association, Division of BRAC
American Train Dispatchers Association
Brotherhood of Locomotive Engineers
Brotherhood of Railroad Signalmen
Brotherhood Railway Carmen of the United States and Canada
Brotherhood of Railway, Airline and Steamship Clerks, Freight Handlers, Express and Station Employees
Hotel & Restaurant Employees and Bartenders International Union
International Association of Machinists and Aerospace Workers
International Brotherhood of Boilermakers and Blacksmiths
International Brotherhood of Electrical Workers

International Brotherhood of Firemen & Oilers
International Longshoremen's Association
National Marine Engineers' Beneficial Association
Railroad Yardmasters of America
Sheet Metal Workers' International Association
Seafarers International Union of North America
Transport Workers Union of America
United Transportation Union

This nation's Railroad Retirement System antedated its Social Security System. In fact, the original Social Security Act based its tax benefit separation scheme on that developed in the 1935 Railroad Retirement Act. There are today some 1,000,000 persons receiving benefits under the Act, many of whom devoted their working lives to the railroad industry in large part because of the existence of the Retirement Act. Everyone of the persons actively employed in the industry today began his or her railroad career protected by the provisions of that Act.

In its budget for fiscal year 1986, the Administration has recommended that taxes on some portions of the Tier I annuities payable under the Railroad Retirement Act be increased. This would be accomplished by treating those benefit amounts like private pensions for tax purposes rather than like social security benefits as current law provides.

The reason for this tax increase proposal is, of course, it would appear to produce additional revenue for the Federal government, thereby reducing the budget deficit to a minor extent. Obviously, any tax increase will reduce the deficit to some degree. However, we must strongly object, and we believe any fair-minded person would also object, to a proposal which would increase the tax burden on only one segment of the public - and at that a segment consisting entirely of elderly and disabled persons - at a time when the Administration is adamantly opposing tax increases on an across-the-board, even-handed basis as a means of dealing with the Federal deficit. This tax increase proposal is particularly objectionable in view of the fact that the increase would come on top of another tax increase effective in 1984, when railroad retirement annuities became taxable for the first time in the 50 year history of the Railroad Retirement system.

From the time of the enactment of the Railroad Retirement Act in the mid-1930's until 1983 it had been the policy of Congress to exempt from taxation the benefits payable under that Act just as it had been Congressional policy to exempt from taxation benefits payable under the Social Security Act. This longstanding policy was specifically reaffirmed by legislation in 1955 after it appeared that the enactment of the Internal Revenue Code of 1954 might have inadvertently removed the exemption with respect to railroad retirement benefits.

Nevertheless, in early 1983 when legislation dealing with the financial problems of the Social Security system imposed a tax on social security benefits, it was considered equitable by all the parties involved to tax Tier I railroad retirement annuities in the same manner because those annuity amounts are computed under the social security benefit formulas and are based on a railroad worker's combined railroad and social security earnings. Also, when legislation was enacted later in 1983 to restore the Railroad Retirement system's solvency, it was considered acceptable to tax Tier II railraod retirement annuities in the same manner as private pensions because those annuity amounts are often viewed as being comparable to benefits paid under private plans. Consequently, in the very recent space of 12 months the retired, infirm and widowed in the railroad industry have suffered two tax increases. To increase further the tax burden on these retired and disabled railroad workers only two years after these previous increases is, in our view, totally unsupportable. This is particularly true at a time when the general policy of this Government is to reduce the Federal tax burden on individuals.

The reason given by the Administration for its proposal is a claimed belief that the Tier I component of railroad retirement annuities exceeds what Social Security would pay to 50% of those receiving Tier I benefits. The excess is currently taxed under existing law as a result of the 1983 amendments but the Administration believes the excess should be taxed at the higher rates applicable to private pensions. All components of railroad annuities other than Tier I are already taxed at those higher rates.

It has been claimed that this proposal is merely a "technical and conforming amendment" but the Administration and its other advocates should acknowledge it for what it really is - a tax increase on the elderly, the widowed and the infirm in order to lower minutely the budget deficit. It is cynical in the extreme to deprive 500,000 ill and elderly Americans of $160,000,000 of their already small incomes under the guise of a "technical" or "conforming" amendment. The extraction of this enormous sum of money from these few people is not "technical" or "conforming" in any sense - it is a selective, discriminatory tax increase unjustified by any public need or good; indeed, it is a disservice to the Congress to seek its approval of such unfair, unnecessary and harsh legislation.

The President has indicated he is opposed to any tax increase. Many in Congress have accepted and even endorsed this position. This proposal, however, would raise $160,000,000 in taxes over three years from 500,000 elderly and disabled railroad annuitants while not increasing anyone else's taxes, including the many corporations and super-wealthy individuals who will continue to pay no income taxes at all; that is impossible to explain or justify on any ground.

Beyond its inherent injustice, the Administration's proposal would present an administrative nightmare. Fifty percent of all annuities would have to be entirely recomputed. Many of the computations would require additional information not now available to the Railroad Retirement Board. There is a real concern that this proposal could not be implemented in the time allowed without jeopardizing on-going annuity payments.

The tax revenue to be received by the Government under this proposal would go to the Railroad Retirement Account. The retirees and others affected will want to know why they are being hit with a third new tax on their annuities because they know the account is now solvent and does not need this money. They will view these tax increases as being in reality another benefit reduction - and one accomplished through the back door. Those affected by this proposal know that one reason for the account now being solvent is that they have already had three benefit reductions: of their last three cost-of-living increases, one was delayed, one was wiped out entirely, and the last was reduced. The Administration's proposed tax increase is an unprecedented fourth straight hit which railroad annuitants will take alone; thereby providing them with the dubious distinction of being the only group of citizens in this country so treated. It will be hard for them to understand or accept this kind of "special" treatment.

We also object to a legislative policy which would consider this single, isolated tax proposal as a means of reducing the

Federal budget deficit. It is directly contrary to the announced and accepted Administration and Congressional policy of dealing with all tax measures in connection with the tax simplification and reform proposal. If this proposal were dealt with in that forum, at the least the harsh and unwarranted impact of a tax increase on railroad retirement annuitants might be ameliorated to some extent by revisions to other parts of the Internal Revenue Code which lessen the tax burden on lower income taxpayers. We respectfully submit there is no justification, equity or fairness in imposing a tax increase upon a select group of elderly and disabled citizens while deferring to some uncertain future date the question whether highly profitable corporations and many super-wealthy individuals should pay any tax at all.

We are told the Congress will soon address tax simplification at which time the issue of fairness will be addressed. If the rules for taxing railroad retirement annuities are to be changed, that is the time to do it. That is when offsetting adjustments, if they are warranted, would be made. That is when the proper amount of tax each individual, and each corporation, should pay will be determined. Railroad annuitants should not be singled out and required to pay additional taxes at this time by this vehicle.

The Railroad Retirement Account does not need the $160,000,000 at this time so why is this tax increase now being proposed? The only answer is that it will reduce the budget deficit. An Administration which will not increase the taxes of the wealthy or of corporations in order to balance the budget apparently won't hesitate to advocate a proposal which would raise the taxes of the elderly and disabled in order to do so. That is sad. Beneficiaries of a solvent entitlement program --a program which they have earned-- will suffer a reduction in their incomes ranging up to $700 or $800 a year in order to offset unresolved deficits elsewhere in the Federal budget.

It seems to us quite difficult to claim that we are still a nation "for the people" when we would treat our elderly and infirm citizens in this manner.

We strongly urge that the Administration's tax increases proposal be rejected.

Thank you for this opportunity to present these views of rail labor and the active and retired employees we represent.

The **Chairman**. I have no questions of the panel. Fortunately, this is an issue that at least is easily understandable. We get some others that, frankly, I don't even understand.

You have got a difficult situation, and you have got equities on both sides of this. The workers are entitled to what they are entitled to and we haven't got enough money. Everyone understands that.

Anytime Mr. Myers comes and makes a recommendation, I am very inclined to listen to him. I have listened to him for years when he was a Social Security actuary. And he has appeared in a variety of capacities after he retired.

I don't have any questions.

I understand the problem exactly.

Thank you very much.

[Whereupon, at 11:38 a.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

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ARS

ACTUARIAL RISK SERVICES, INC.
111 Barclay Boulevard
Lincolnshire Corporate Center
Lincolnshire, Illinois 60069
(312) 634-0098

May 22, 1985

Mr. Jim Demarce
Associate Director
Office of Worker's Compensation Fund
U. S. Department of Labor
Suite C-3520
200 Constitution Ave. N.W.
Washington, D.C. 20210

Dear Jim:

Pursuant to the arrangements with you, other Department of Labor staff, and Actuarial Risk Services, Inc.'s clients, we have reviewed the population and benefit outlay sections of the Department of Labor's computer model of the Black Lung Disability Trust Fund, on behalf of our clients. As has been discussed with all of the parties involved, our review has been conducted within a very short time-frame and is not intended to be either complete nor comprehensive as to all of the aspects of the model and its projections. In the time available, we concentrated our efforts in identifying those aspects of the population and benefit outlay portions of the model which could have material affects on the benefit outlay projections if they were computed differently, and we also reviewed how the entire set of benefit assumptions used in the model interrelate.

We understand that the Department of Labor staff working on the model have, since our review began, made changes to the model which may affect some of the concerns described below. We will be pleased to review these efforts and revise our review accordingly, upon receipt of the later version.

We began our review with an examination of the data used by the "current" model to describe the Trust Fund population for computational purposes. This data consists of four principal data sets, as follows:

1) The number of claimants and their survivors in payment status.
2) The age distribution of the miners and their survivors.
3) The proportion of single miners, married miners and widows to the population.
4) The proportion of the population with minor dependants.

The current model uses the following array of claimants in payment status, by year, since 1981, in projecting benefits.

	1981 BEGINNING "STOCK"	1982	1983	1984
		ACTUAL ADDITIONS		
Single Miners	9,748	383	38	73
Married Miners	46,682	4,864	1,841	1,185
Widows	29,149	1,907	719	382
TOTAL	85,579	7,154	2,598	1,640

We find that the numbers of claimants shown above are consistent with data we have received by the Department of Labor over time, during the same period, and consistent with the data used in previous Department of Labor models of the Trust Fund. We understand, but have not verified, that the population data is derived from the data base used to issue checks to Trust Fund beneficiaries.

The situation is less clear as to the age distributions used in the model. The original model of the BLDTF employed an age distribution computed from data as of a date late in 1979. We had pointed out, in previous reviews of earlier models, that this data was of questionable applicability to projections starting in 1980 and 1981. We find, however, that this same data set was used in the version of the model distributed to various parties to date, and otherwise known as the "current" model, which begins in 1981 with historical data. The use of the 1979 age distribution in a model beginning in 1985 is clearly inappropriate, and results in projections of future benefit curves which reflect age distributions that do not precisely match the population as it currently exists.

We have also received from the Department of Labor an age distribution of the data base as of 9/84. The 9/84 age distribution is clearly the more correct choice to use.

In the case of both the 1979 and the 1984 age distributions, we have not been shown the underlying data and algorithms which were used to calculate the number of claimants at each age. Given the known deficiencies in the Department of Labor Black Lung claim data base, we feel certain that significant numbers of individual claims have blank, or otherwise incorrect date of birth entries, so the methods used to adjust and correct such entries in the computation of the overall average age may be of material significance.

In reviewing the model, we have determined that a number of the assumptions and procedures used may not be the most reasonable in projecting the future benefit projections of the model. The areas of concern that we have identified to date include:

- The manner in which the model applies age distributions and beginning populations to begin the projection.
- The procedures used to introduce benefit flows for minor dependants.
- The treatment of Responsible Operator claims in interim pay.
- The treatment of Trust Fund denials which are being successfully appealed by the claimant.
- The source and accuracy of the age distributions used in the model.
- The mortality assumptions used in the model.
- The statistical adjustments used in the model to modify the beginning and subsequent population "stocks" and benefit flows.

A discussion of each of the items enumerated above, appears in the Appendices of this report.

The general direction resulting from the correction of the items of concern raised above is to reduce the projected benefit flows, as put forth in the current model. The reduction in benefit flows is most pronounced in the far-term portion of the projection. Our initial estimate, based on a relatively incomplete analysis of all of the variables, indicates that the overstatement, as measured against the current model, is in the range of 10% to 20%. The estimated overstatement is quite dynamic with respect to a large number of assumptions used in the model, and can be expected to vary up or down if other combinations of facts and assumptions are incorporated in the model.

We would suggest that, if the model is to be used as a credible representation of the likely Trust Fund benefit outlays, the following should be done:

1) Test, document, and present the underlying data and procedures used to construct the age distributions, marital statuses and proportion of minor dependant assumptions employed in the model.
2) Begin the projection with an age distribution calculated as of the date of the projection.
3) Base any statistical adjustments to the population or benefit flows on events relating to known mortality experience only.

4) Model, separately, Responsible Operator interim pay claimants and new entrants resulting from Trust Fund denials being reversed upon appeal.

5) Make reasonable assumptions as to the limited period that minor dependants will be paid, step 3 and/or 4 benefits, and appropriately reduce the initial projected benefit rates.

6) Conduct a mortality study of the Trust Fund population so that the appropriate mortality assumption may be employed in the model.

7) Apply an appropriate age distribution to the assumed new entrants.

8) Adjust the assumed rate of widow survivors from the initial group of married miners for the probability that not all of the post-1982 Act surviving widows will qualify for benefits.

Very truly yours,

ACTUARIAL RISK SERVICES, INC.

Robert K. Briscoe
President

RKB/lag

cc: Bruce Watzman - National Coal Association
Roy Kallop - National Council on Compensation Insurance
Actuarial Risk Services, Inc. Clients

APPENDIX I

APPLICATION OF AGE DISTRIBUTION TO MODEL PROJECTION

Actuarial valuations of benefits payable to individuals are normally valued on an individual, person-by-person basis. This holds true for life insurance, pensions, and insurance claim reserve calculations. An individual, claim-by-claim valuation is, in theory, no more accurate than a valuation employing an average age distribution if the average age is calculated and applied in exactly the right manner. The individual, person-by-person valuation is preferred because it minimizes the number of assumptions which must be employed.

Our concern with the current Trust Fund model is that it not only relies on the application of an average age distribution, but it also attempts to apply that age distribution in a manner which is likely to be mathematically incorrect.

Our concern is the beginning date of the valuation. The normal procedure in making projections of this nature is to establish a valuation date from which all events begin, or are measured.

The Department of Labor model does not employ this structure. Instead, the data input to the model begins in past years, and is brought forward to the present by adding actual historical data, at which point the projection begins. The process of bringing all of the data employed in the projection to a common starting point has been a problem in both the Department of Labor's former and current models. The principal difficulty has always been the age distribution used, which has been compiled from some past period and then applied to a projection starting from a later period. Mismatches in the timing of the application of the age distribution tend to overstate the projected benefits because the age distribution of the essentially closed group of Trust Fund beneficiaries will change shape as deaths are removed year-by-year. Unless the program models the exact pattern of actual deaths, the changing shape of the age distributions will not be properly recognized and, in general, will result in the projection of a younger group than is actually the case.

The current model attempts to adjust for the gap between the age distribution and the beginning of the projection by seeking to change the number of claimants during the period between the initial population entered and the beginning point of the projection in such a way that the program will have correctly adjusted the initial age distribution by the time the projection is begun. While such adjustments could add ultimate accuracy to the projection, they are completely dependent upon a full understanding of all movements of the claims population during the period in question. Given a less than perfect understanding of those movements, the adjustments add nothing over the alternative of simply using a current age distribution applied to the current population. A further discussion of the adjustments will follow in Appendix II.

APPENDIX II

STATISTICAL ADJUSTMENTS

The statistical adjustments used in the model to attempt to correct the difficulties encountered in matching demographic data with the timing of the model represent a theoretically correct, but troublesome, methodology for making a reasonable projection. If the only reason for a change in the number of people in pay status from one period to the next since 1981 was the death of the claimant or the death of a female dependant, then the adjustment mechanism used in the current model would provide a means for adjusting the mortality assumption to conform to the actual experience. In fact, however, a fairly large number of other reasons for "exits" from the populations were also present during the period in question, and some will continue into the future. They include modifications of claims, the effect of appeals of Department of Labor decisions, elimination of duplicate entries in the data base, the effects of state offsets and various other events, all of which either stop payments on a claim for which payments were being made, or begin payments on a claim. The current model adjustments attempt to project the effect of all of the above across the entire future of the Trust Fund and represent, at best, a very crude initial adjustment which may improve over time as the number of non-mortality exits from the Trust Fund presumably decrease in number.

We feel that the model would be better presented with current demographic data used to begin the projection, and any adjustments which should be made arising out of a formal mortality study. The current model, with the adjustments, will, at best, always present a projection which is difficult to follow and describe.

We would also note that new entrants to the Trust Fund population in future years are brought in at the same average age as the current population. This almost certainly will not be the case, however, since the number of assumed new entrants is small, so the current procedure causes no significant distortion. Material distortions could occur if larger numbers of new entrants were to be assumed.

R/O INTERIM PAY AND DENIALS REVERSED ON APPEAL

The beginning "stock" of married miners, single miners and widows used in the model apparently include 6,000 responsible operator interim pay cases which were in payment status at that time. The additional claims added between 1982 and 1985 also include new interim pay cases. These interim pay cases will all follow the same progression, eventually reaching a hearing, and either being paid by the coal operator or being denied. In either case, the claim will no longer be paid by the Trust Fund. The general time-frame of the hearing process should see the majority of the cases reach a hearing during the next five years, with some possibility that the process may be accelerated. The interim pay cases have the further characteristic of being composed of the younger portion of the current Trust Fund population. We would estimate that the average age of the interim pay population is between 55 and 60, as opposed to an average age of 65+ for the entire population.

The current model also does not implicitly recognize new claims entering the model as the result of currently denied claims being awarded upon appeal. The Department of Labor staff estimates that the two groups of claimants - interim pay and denials awarded upon appeal will ultimately be of approximately the same size, and, therefore, the current model contains approximately the correct number of claimants. Even if it ultimately proves to be true that the number of claims will be equivalent, we feel that the age characteristics of the two groups will be quite different - the interim pay group being young, and the Trust Fund denial being considerably older. The current model then projects the younger group when, in fact, an older group will replace them. This leaves the current model overstating benefits based upon the younger group.

We recommend that the two groups be introduced into the model separately and projected on the basis of their respective age and other demographic characteristics.

PROJECTION OF STEP 3 AND STEP 4 BENEFITS

The Federal Black Lung Program pays benefits which vary as a function of the number of dependants the claimant has at any point in time. The model correctly projects the step 1 and step 2 benefits payable to single miners, married miners and widows. The program further assumes that certain percentages of the single, married and widow population will have additional dependants. The benefit flows based upon the single, married and widow populations are then increased to adjust for the step 3 and step 4 benefits payable to the additional dependants. While some added precision could be obtained in the model by calculating the additional dependant populations explicitly, instead of applying a factor to the benefit flows, we would agree that the complexity of the computer code needed to do so is probably not worth the added precision which would be achieved in the calculation.

We do not agree, however, that the loading for these dependants be continued throughout the projection. In fact, the majority of the additional dependants will be minor children whose benefit will end at age 18 or 24 depending on the educational pursuits of the child.

Based upon our Federal Black Lung data base, the average age of these minor dependants is approximately 14 years in 1985 and the average age of male claimants with children under 18 is 50. If we assume that there will be relatively few new children from the current Trust Fund population, then the added benefits should reduce to a very small number over the next 5 years or so.

We recommend that the step 3 and step 4 benefits, currently being applied to the current model for the full term of the projection, be graduated downward to a very small additional loading after 1990 or so. This will produce a significant reduction in the projected benefits after the point at which the loading is reduced.

APPENDIX V

MORTALITY

The issue of the correct mortality tables to be used in the Trust Fund model has been discussed for the last five years or more. (See our previous reports to the Department of Labor on the previous model.) In summary, we have provided the Department of Labor a set of male and female mortality tables (1971 Group Annuity Mortality Tables), which have been used by the Department of Labor in the current model, that our firm has found to be the best representation of mortality experience for male responsible operator claimants. We have not had the data, or the opportunity as yet, to study the mortality experience of the female survivors of Black Lung claimants, and have not studied at all the mortality of the Trust Fund population. We know that the Trust Fund population is older, and generally represents a previous generation of coal miners as compared to the responsible operator claimants. Their mortality may well be different than that of the R/O population. We have recommended, for more than three years, that a specific mortality study be done on the Trust Fund population, and we continue to do so. If the mortality experience of the older portion of the Trust Fund population ultimately proves to be different than that of the R/O population, we would expect the life expectancies to be somewhat shorter, and the current model, therefore, would overstate the benefit flows. We suspect that the most uncertain aspect of the mortality is that of the female dependants, which have not been studied by anyone to date.

The size of the Trust Fund population is such that a fully credible mortality study is possible given sufficiently accurate and timely death reporting.

Statement of

JAMES I. CAMPBELL, JR.
Legal Counsel, International Committee
AIR COURIER CONFERENCE OF AMERICA

before the
COMMITTEE ON FINANCE
UNITED STATES SENATE

on the subject of
"Users Fees" for the services of the
United States Customs Service

September 11, 1985

I. INTRODUCTION

I am James I. Campbell, Jr., legal counsel for the International Committee which has been established under the aegis of the Air Courier Conference of America (ACCA).

The International Committee was established by ACCA this past summer to provide a forum for the development of a common industry position on governmental issues involving the international transportation of urgent small parcels. ACCA itself includes more than one hundred member companies, ranging from the very small to the very large. All specialize in the business of providing or facilitating the rapid and reliable door-to-door transportation for time-sensitive small parcles. Pick up and delivery is effected by specialized messengers. The intervening air transportation is handled differently by different members; some use the airline baggage system, some the air cargo system, and some their own aircraft.

The members of ACCA handle the great majority of all the urgent small parcels being transmitted into and out of the country, even if one includes the U.S. Postal Service's International Express Mail service and the express services of the airlines. In addition to ACCA members, the International Committee also includes several large, non-ACCA companies which have recently decided to enter or to enlarge substantially their participation in the international small parcel express market; the latter include companies such as Emery and Airborne Express.[1]

On behalf of the great majority of the carriers of urgent international small parcels, I am today testifying in support of the concept of users fees for customs services and proposing the specific application of this concept to couriers and their competitors. We greatly appreciate this opportunity to present our views to the committee.

II. A THUMBNAIL SKETCH OF THE INTERNATIONAL COURIER INDUSTRY

The term "courier" has changed and evolved with the industry, so it is helpful to begin with a definition. The term today refers to a company that specializes in the rapid, door-to-door transmission of small, urgent business documents or parcels. A courier is essentially a pick up and delivery company whose operations are closely coordinated with the international airline system. Generally, a courier will only accept a container of documents or parcel that weighs less than 70 pounds, the maximum weight of a piece of baggage aboard most commercial airlines.

There has evolved a reasonably standard bundle of services associated with the idea of a "courier." A courier will usually pick up a parcel of business documents or other items in the evening and dispatch it from the origin city by aircraft that night. The parcel will be delivered to a destination address within a few business hours after arrival at the airport nearest the addressee. "Business hours" refers to hours during which business is normally conducted, a convention which differs substantially in different parts of the world. Within the United States, parcels are generally picked up after four o'clock in the afternoon and delivered by 10:30 the next morning. International shipments from the east coast are delivered to major European and South American cities by midday the next day and to major cities in the Middle East and Far East on the second day following pick up. In addition to speed, the typical courier offers other services upon which its customers depend. The courier will pick up on demand at the shipper's office. A proof-of-delivery receipt will be returned to the sender, if requested. The courier can and often does trace documents quickly in case of problems. Couriers also automatically insure against the cost of reconstructing lost documents (although not other, consequential damages).

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[1] Federal Express, an ACCA member, has declined to participate in the International Committee, and so my remarks should not be construed as representing that company. As a new entrant, Federal Express is, so far at least, a relatively small factor in the international express industry outside of U.S.-Canada traffic.

Historically, air couriers usually transported documents as the baggage of a company employee, an onboard "courier" passenger, traveling on a regular commercial airline flight. Passenger baggage is used because it is guaranteed to be boarded on the flight (general cargo is not) and because customs clears baggage immediately but often takes many hours or days to clear cargo. Gradually, airlines and customs are beginning to adapt to the needs of couriers so that today, on some routes, couriers in fact make greater use of cargo services. The volume of international courier shipments is also beginning to justify the use of dedicated cargo aircraft. As electronic transmission of documents becomes more feasible, some couriers will also use telecommunications to move documents from city to city. As the essence of a courier's task is the pick-up and delivery, this change in technology will not alter the basic concept of "courier." (Of course, it is possible that pick-up and delivery will be unnecessary in the future, eliminating the need for "couriers.")

As defined, "courier" service could include international express mail. Indeed, some post offices refer to their express mail services as "postal courier." Nonetheless, for the purposes of this statement the term "courier" does not include express mail services. Following the terminology of the Universal Postal Congress, rapid postal services designed to compete with the couriers will be termed International High Speed/Express Mail Services, or for short, "postal express" services.

Private courier companies began business in North America and Western Europe in the late 1960's. The first couriers evolved from the armored car companies who provided banks with secure transportation of financial instruments. As modern business expanded to international scope, banks extended their operations and the time required to transport financial instruments from one bank to another increased accordingly. The interest that accrued on financial instruments while in transit soon became very significant. To reduce this lost interest, armored car companies began a specialized air transportation service in which an employee would pick up the bank documents from the sending bank, carry them as baggage aboard a regular commercial airline flight, and then immediately deliver them to the destination bank.

Today international courier services serve primarily the international service industries. Financial institutions transport checks and other monetary instruments by courier to avoid the loss of interest which could amount to hundreds of thousands of dollars per day. Transportation companies forward bills of lading so that customs clearance can be expedited in advance of the cargo, thereby saving thousands of dollars in unloading delays. Engineering and construction firms manage projects by forwarding drawings, bids, and project reports by courier for next day delivery. Many multinational organizations are dependent on international couriers to provide a network for the flow of information necessary for managers to direct and coordinate widely separated activities.

Unfortunately, there are no reliable studies or statistics on the worldwide international courier industry. A reasonable estimate would be that international couriers today earn about US$ 1.75 billion on a worldwide basis. The industry is growing at approximately 25 to 40 percent per year. Very roughly, in 1985, the couriers will transport approximately 14 million shipments of documents and small parcels weighing 54 million pounds into or out of the United States. We estimate that the couriers transport more than 2 billion pages of urgent commercial information each year. The couriers' shipments are consolidated into approximately 1 million shipping bags, weighing 30 to 70 pounds each. Of these shipments, about

80 percent contain only business documents, with the remainder containing dutiable and non-dutiable samples, spare parts, etc.[2]

The current importance of the courier sytem in U.S. international commerce is illuminated by comparisons with other types of communications. It must be kept in mind, of course, that each mode of communications has its own distinct advantages and that comparisons necessarily contain oversimplications. With this caveat in mind, we can note that the United States Postal Service annually transports approximately 1 billion international airmail letters (in and out of the U.S.) weighing about 125 million pounds. In terms of weight, then, the courier system is almost one half the size of the international air mail system; in terms of the quantity of urgent commercial information transmitted, the courier system is far larger than the postal system. The United States also annually places or receives about 1 billion international telephone calls and 30 million telex and telegraph messages. Suppose we make the extremely simplistic assumption that a page of data may be roughly equated to a telephone call or telex message. One would then reach the remarkable conclusion that the courier system probably transmits twice as much commercial information as the international telephone system and 80 times as much as the telex system.[3]

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[2] I must emphasize these figures are very rough. They were projected from a 1984 study by Cresap, McCormick & Paget, an international management consulting firm. The study was organized by the International Courier Conference, the overall international trade association of the courier industry, based in Geneva and London. The CMP study was based upon 1981-83 data obtained from the major couriers. To adjust this data, I used assumed a conservative 20% annual growth by weight. In the revenue figures at the end of this statement, I have assumed that all of this traffic will be subject to the proposed users fees. In fact, a small fraction of courier traffic is today not cleared at a general, port-of-entry airport facility, but flown directly to or shipped in bond to a central hub. Under our proposal, this central hub material would not be subjected to proposed users fees. Customs would, however, collect more or less similar amounts in the form of fees for the assignment of an inspector to a specific courier's hub.

[3] The figures for other communications modes are likewise intended to very rough, providing an order of magnitude comparison. Generally, the figures are informal projections from the latest data available in the 1985 Statistical Abstract of the United States or the 1984 Annual Report of the Postmaster General. For all modes, including couriers, it has been assumed that inbound and outbound traffic are about equal.

The rise of the international courier system during the last ten years may be explained by three important trends in modern international commerce. First, the most apparent development has been rapid growth in the quantity of imports and exports. Inevitably, more trade means more documentation. A second important trend has been the changing character of international trade. Increasingly, the United States now sells high technology goods and services to the rest of the world. As the U.S. Trade Representative put in its recent report on trade in services to GATT: "[C]ommunications are becoming more central to the global company. Communications serve the same function for trade in many services as the transportation system does for trade in goods [page 15 (emphasis added)]." The third trend that should be noted is the increasing geographic diversification of international trade. Well known examples of this phenomenon include the increase in the sale of engineering services in the Middle East, the increase in banking activities around the world, and the increase in trade with Asia. The changing geographic scope of international commerce is important because many of the less developed countries do not have the postal and telecommunications facilities that are available in the developed countries. Business activities in the less developed countries are therefore especially dependent upon private couriers.

III. WHY THE COURIER INDUSTRY SUPPORTS USERS FEES

The couriers specialize in the transportation of very time-sensitive documents and other small parcels. Any delay in the transmission of these parcels diminishes their value to our customers and, quite directly, hinders the competitiveness of U.S. international business. We believe, therefore, that it is in the vital interest of our customers and of U.S. commerce generally for the United States to provide customs inspection and entry of these urgent international trade shipments as quickly as possible. Indeed, we would respectfully suggest that, from the standpoint of the national economy, the checks, bills of lading, tender offers, blueprints, samples, spare parts, etc. carried by couriers are more urgent than any other identifiable category of traffic on the aircraft — more urgent than the average passenger, the average passenger bag, the average cargo shipment, or even the average perishable cargo shipment (such as fruit or flowers). Please note here that I do not suggest that this urgency arises from any skill, merit, good looks or other quality of the couriers themselves. The urgency arises from the time-sensitivity of the information and items being carried and the value of timely delivery of these shipments to U.S. international business generally.

In short, we are suggesting that it should be forthrightly recognized and admitted courier shipments require high quality customs service. Philosophically, it seems to us fair and desirable that those who make use of customs services bear the governmental costs generated by these commercial requirements. (Of course, it is the final consumers of the products or services facilitated, and not the customs "users" nor their customers that ultimately pay the bill.) If "users fees" are to be the accepted means of financing customs services, then the couriers should be included, most particularly because of their need for very high quality customs services. Indeed, direct remuneration to Customs for services rendered may well make it easier for Customs officials and ourselves to work out flexible and mutually satisfactory arrangements to meet the special needs of urgent parcels. As we see it, this increased ability to work flexibly with Customs can smooth the way for future improvements, as well. In addition, users' fees will cure one serious flaw in the current system. The fact that direct compensation to Customs is now generally limited to overtime services creates a financial incentive for individual Customs officials to delay clearing courier shipments until after overtime goes into effect. While infrequent, the perverseness of the current scheme has resulted in unnecessary delays for couriers in some cases.

We do not believe that users fees for customs' inspection of courier shipments is tantamount to asking a victim to pay the police for catching a criminal. Clearly, the inspection of shipments entering the United States is intended to protect the health and welfare of the public as a whole. Equally clearly, there would be no need to inspect international shipments if there were no international shipments. Couriers and their customers have voluntarily engaged in international trade for profit and, in so doing, have given rise to a reasonably allocable governmental expense, the cost of inspecting the resulting shipments. In contrast, the victim of crime has hardly given rise to governmental expenses through voluntary, commercial activity.

IV. SOME CONCERNS ABOUT USERS FEES

Our friends in the international airline industry, and others in the international transportation field have generally reached a different conclusion on the merits of the customs users fees concept. While we in the courier industry see the matter differently, at least with respect to international courier shipments, this is not to say that we do not have concerns with some aspects of the users fees concept, including some of the points raised by the airlines.

Our first concern (not raised by the airline industry) would be that users fees, as well as all other aspects of the customs laws, be written and enforced so as to provide evenhanded application to all services competing with the couriers. Of particular concern in this regard is the international express services of the U.S. Postal Service. To illustrate our point, we can relate that last year an independent accounting firm conducted a test of thirty shipments imported into the United States by means of the Postal Service's International Express Mail program. All shipments were properly marked by the accounting firm as having a value of between $100 and $400, yet duty was collected on only one shipment. Such flouting of the U.S. Customs laws is, of course, impossible for the couriers and gives the Postal Service a relative competitive advantage.[4]

Other competing private transportation modes should likewise be treated in an fair manner relative to courier traffic. The airlines' international small parcel express services, which have been established to compete with the couriers, should be treated identically to the couriers. Customs should also take care that its fees for the assignment of inspectors to central hub facilities of large express companies are reasonable compared to users fees; neither way of clearing customs should result in a non-cost justified comparative advantage. By the same token, it is also fair and reasonable that the proposed users fees for courier traffic ensure a high quality, expedited Customs service that is substantially superior to that afforded the general freight industry, which has so far successfully opposed payment of users fees.

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[4] The same accounting firm is conducting a followup test of this phenomenon this fall and, if the same bias is detected, the courier industry expects to seek redress in the appropriate forums.

A second concern is the question of establishing an unfavorable international precedent. The airlines have correctly noted that foreign governments may use a users fee law in the U.S. as an excuse for a less fair, less reasonable tax on international commerce in their countries. For this reason, we urge this committee to include in its report a detailed explanation of the rationale for the users fee concept and a full justification for the charges levied. With an explanation on the record, it will be easier for reasonable men in foreign governments to oppose charges which exceed the levels implied by the clear reasoning of this committee. While this proposal may not completely eliminate all precedental concerns, we would also note that any precedental problem created by users fees is not as serious as it would be if the concept represented a completely new position on the part of the United States. "Users fees" of one sort or another have long been imposed on some users of customs services, such as those who require entry outside of normal business hours.[5]

Third, we agree with the concern voiced by the airlines that there are inherent dangers in establishing any organization, including the Customs Services, as a monopolitistic supplier of essential services. This is a fundamental issue which goes far beyond the users fee concept, but it is a valid point, which this committee should keep in mind in its continuing oversight of Customs.

We also agree with the airline industry that a close check must be kept to see that the money raised from users fees results in customs services which meet the needs of the payors. In this regard, the advisory committee established by the House bill, H.R. 3128, seems to us highly desirable. In the same vein, a detailed public disclosure of how the fees are calculated, collected, and used is also necessary. The "user" should pay no more than the "fee" reasonably and directly allocable to him. Similarly, the user should be able to rely upon the fact that the customs services "purchased" meet appropriately high standards. The 45-minute processing time for passenger traffic, for example, seems a reasonable standard for courier traffic as well, in view of the fact, noted above, that the courier traffic is if anything more urgent than the average passenger. Moreover, where appropriate, the Customs Service might be required to contract out services to private parties if such services can be performed more efficiently in this manner.

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[5] We take no position on the objections based upon international law, GATT and the Chicago Convention; for the purposes of this statement, we have assumed the legality of the concept. We note, however, that the courier industry does not pay significant customs services users fees in any other country. For this reason, we urge the the committee to examine the legal and precedental issues with great care.

Finally, we would note that the reasonableness of users fees relates, in turn, to the reasonableness of the customs laws themselves. We would hope that adoption of a users fee concept will also lead to a more careful cost/benefit analysis of some of the more burdensome customs laws. Users should not be asked to bear the costs of administering customs laws which yield far less in revenue or other public benefits than they cost to administer.

V. A PROPOSAL TO APPLY USERS FEES DIRECTLY TO THE INTERNATIONAL EXPRESS INDUSTRY

With respect to the specifics of our industry, we believe that it would be reasonable and fair to apply the customs users fees concept directly to courier shipments, international express mail shipments, and airline express shipments. Two types of users fees are needed. The amount of work required to clear business documents is distinctly different from clearing other types of shipments. Business documents are subject neither to duty nor to entry formalities. They are "intangibles" under U.S. law. 19 U.S.C. 1202 General Headnote 5. Customs inspectors need only inspect a sampling of the documents to satisfy themselves that the documents are, in fact, documents. Other express items, whether or not dutiable, require more work: entry and the payment of duty, if applicable (even in such cases, however, entry is generally informal). Hence, what is needed is a fee for intangibles and a fee for tangibles, stating according to some convenient unit of measure.

It seems to us that that it would be most practical to base customs fees on the most easily quantified and readily apparent measure of express traffic, the courier's shipping bags. In line with airline restrictions on passenger baggage, these bags weigh up to 70 pounds (averaging perhaps 55 or 60 pounds). Couriers will usually use such shipping bags regardless of whether the bags are shipped as a passenger's baggage or as freight. The postal express services use similar, somewhat smaller shipping bags. A small fraction of express shipments are packed loosely, "bulk loaded" by an airline or "containarized" by a courier. To accommodate such operational variations, we propose that Customs have authority to adjust the bag charge in a proportional manner.

An average courier bag of "intangible" business documents contains about 15 to 30 separate envelopes. An individual courier passenger carries anywhere from two or three to 20 or more bags. Since U.S. Customs requires that the intangibles bags contain no tangible items and is enforcing very strict operational penalties if tangibles are found, it is very much in the courier's interest to keep the intangibles bags "clean." The clearance of these intangbiles bags is therefore very straightforward. There is no paperwork. A random sampling of the bags can be performed quickly. Since irregularities are very rare, this is usually sufficient to satisfy the Customs inspector of the contents of the total shipment. We estimate that, on the average, a Customs inspector should be able to clear a courier and 25 bags of intangibles in substantially less than an hour. According to the house bill, the fee for clearance of a passenger would be $5. Therefore, if each bag of intangibles is subject to an inspection fee of $1, this would yield to Customs a return of $30 ($5 for the passenger and 25 times $1 for the bags) in, we believe, considerably less than an hour on average. While $30 for less an an hour's service is significantly higher than Custom's actual average costs, we are proposing this level of users fee in recognition that the couriers require significantly better than average customs services.

The clearance of bags of tangibles is somewhat more complicated. The courier retains a customhouse broker to prepare the necessary paperwork for formal or informal entry. At a minimum the paperwork will include a master manifest which lists, for each separate shipment, the name and address of shipper and consignee and a description of the value and nature of the goods shipped. Based upon the information supplied, the inspector may ask to see some or all of individual shipments or inspect them on a random basis. While small parcels are generally subject to a higher degree of scrutiny than business documents, it is, of course, extremely rare that Customs inspects all parcels. We estimate that a Customs inspector can easily inspect and clear a courier and six bags of tangibles bags in an hour. If we aim for a total fee of $30 per hour, as above, this would imply a users fee of about $4 per tangibles bag.

Our proposed users fees would not apply to express shipments which are transported aboard freighter aircraft or shipped directly, or in bond, to a central hub for clearance. If a courier or express company operates its own aircraft and clearance facilities, it is already paying Customs a fee for the assignment of inspectors. While it is important that these "assignment" fees bear a reasonable relationship to the proposed users fees, clearly such traffic should be exempted from the proposal. In an effort to promote clarity, the proposed users fee rule would also automatically exclude shipments weighing more than 70 pounds. This limit avoids true "freight" shipments and includes all but a very small handful of truly "time-sensitive" shipments.

I emphasize that we are proposing these fees with the understanding that the couriers — and other affected parties — will receive the high quality customs services paid for. Hence, our proposal is requires "expeditious" clearance services. We are not volunteering to pay extra fees only to be told to wait at the end of the line while the "important" traffic is cleared.

Please note as well the above estimates of clearance times and Customs cost are extremely rough and must be refined through further work with the committee and the Customs Service. Allowing for further refinement of the actual amounts of the fees, the international courier industry would support an amendment to the house bill, H.R. 3128 (H.R. Rpt. 99-241), of the following general form:

> On page 107 at line 10, in the new language inserted in 19 U.S.C. 58a by section 251 of the bill, insert a new paragraph (a)(7) following paragraph (a)(6), as follows:
>
> "(7) For the expeditious inspection and clearance of each shipping bag, weighing not more than 70 pounds, of urgent commercial information or other urgent small parcels, arriving in the United States aboard a commerical aircraft (other than an all cargo aircraft): $1 for each bag containing only intangibles, as defined in General Headnote 5, and $4 for all other bags. These fees may be adjusted in a proportional manner for shipments packed in different sized bags or containers, provided no individual shipment weighs more than 70 pounds. These fees shall not apply to shipments transported in bond to an express company's central hub facility to which customs inspectors have been separately assigned.

To add needed clarification, we suggest that the committee's report include an explanation such as the following:

> The "courier bag" fee established by (a)(7) is established for "expeditious" customs clearance of urgent, time-sensitive small parcels, whether transmitted by private international courier or the United States Postal Service (under the International Express Mail program). The fee also applies to other small parcel express service offered by a cargo or commercial airline or air freight forwarder which is held out to the shipping public as competitive with such services. The latter would include, for example, such services as the international "courier" services offered by Federal Express and Emery and the "Worldpak" service of Pan American World Airways. The fees would not apply to shipments arriving in the United States via all cargo aircraft (which are invariably cleared by specially assigning an inspector to the task) nor to shipments cleared at a central hub facility; Customs already charges for the assignment of inspectors to perform such services. The fees are also limited to "urgent" shipments weighing "70 pounds or less." These restrictions are intended to emphasize that the committee's intention that the proposed fees are intended to apply only in return for exceptionally expeditious customs clearance services and not for the routine clearance of general air freight (whether more or less than 70 pounds).

Based upon the rough estimates of the size of the current courier industry given earlier and the very rough fee schedule assumed above, we estimate that the amendment we propose would result in assessing the following users fees from the courier industry:

400,000 bags of intangibles (inbound only) @ $1 each	$ 400,000
100,000 bags of tangibles (inbound only) @ $5 each	$ 500,000
25,000 courier passengers (assuming that half the courier bags arrive by on board courier a rough average of 10 bags per courier) @ $5 each	$ 125,000
	==========
Total "users fees" by couriers	$1,025,000

The above figure is based upon estimated 1985 traffic. The courier industry expects that the traffic will continue to expand at 25% or more per year and that the tangibles traffic will increase more rapidly that the intangibles traffic.

We will be delighted to work with the committee in any way to improve the users fees concept. Thank you, again, for this opportunity to explain the point of view of the international courier industry.

AOPA
AIRCRAFT OWNERS AND PILOTS ASSOCIATION
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STATEMENT OF JOHN L. BAKER, PRESIDENT
AIRCRAFT OWNERS AND PILOTS ASSOCIATION
BEFORE THE SENATE FINANCE COMMITTEE
REGARDING CUSTOMS SERVICE USER FEES
SEPTEMBER 11, 1985

The Aircraft Owners and Pilots Association represents the aviation interests of 265,000 individuals who own and fly general aviation aircraft for business and personal purposes. Many of our members use their aircraft in international air commerce and thus the policies and operations of the U. S. Customs Service are of interest to them.

Our members do not regard customs inspections as a favor or service provided to them in their own interest. Instead, most consider submission of ones property and belongings for inspection and possible imposition of duties as necessary and in the best interests of their fellow citizens. Carried to extremes, the philosophy underlying this proposal could also be construed as an argument to charge for any activity of the Federal government done on behalf of the citizenry. A taxpayer who does not receive his or her social security check could be assessed a service charge for calling to get the problem worked out; the Justice Department could seek to recover court costs for its suit on behalf of a taxpayer or a class of taxpayers in an anti-discrimination case. Someone else already has mentioned to the committee the example of IRS charging to process income tax returns. In theory these acts are not so different from charging a traveler returning to the United States for costs attendant to Customs' inspections. Let us also keep in mind that even before travelers reach the Customs desk they must pass through immigration and naturalization. If Customs is permitted to levy charges above and beyond what U.S. taxpayers already pay through the Federal income tax system, then what is to prevent the imposition of a fee for stamping passports or ascertaining that the returning traveler is a citizen.

What I have just mentioned is but one problem we have with the bill. Let me move on to the second. That concerns provisions of the proposed legislation which address the actual fee schedule. As written the fee schedules are unfair and discriminatory and regrettably, neither the Administration's proposals nor the version approved by the House Ways and Means Committee (H.R.3128) are acceptable.

The Administration has proposed that general aviation be charged $66 per entry per aircraft while railroad passengers be charged 25 cents each. This is obviously unacceptable and discriminatory. H.R.3128 would impose a $25 annual fee on a general aviation aircraft and reimpose the requirement that general aviation pay for all inspections on Sundays and holidays on an overtime basis up to $25 per aircraft. While the House bill is an improvement over the Administration's request, it still fails miserably in the area of fairness.

As it so often the case when faced with deficit reduction efforts, Congress seems inclined to try to extract great revenues from relatively small sources while allowing the potentially large sources to escape. The result is that one small economic activity feels a tremendous bite, but yet from the Federal perspective, revenues are insignificant. By exempting highway vehicles from the charges and focusing on aviation and marine activities, the legislative proposals unfairly discriminate among classes of travelers.

Our members are already complaining to us with great regularity about the imposition of overtime charges on general aviation. They feel that this it is particularly unfair since automobiles and buses are not being asked at this time to pay for after hours inspections. Requiring payment of overtime charges by aviators during regular hours on Sundays and holidays will be met with considerable resentment.

If the Congress is determined to recover part of the Customs Service operating budget from levies upon those who must submit to inspections, we suggest that you consider at least one of the following alternatives:

1. Impose a very modest charge for all inspections based on the number of passengers inspected or the value of imported cargo. All modes of transportation should be treated the same.

2. Increase the fees for passports and credit the increased revenue to Customs.

3. Should Congress increase tariffs on certain products imported from countries which do not facilitate trade with the U.S., credit a small part of the increased revenue to the Customs Service.

In summary, we are opposed to the discriminatory imposition of a $25 fee on general aviation aircraft and we are opposed to the discriminatory imposition of overtime charges on aviation. We appreciate your consideration of our views.

1985

STATEMENT OF STEPHEN A. ALTERMAN
EXECUTIVE VICE PRESIDENT AND COUNSEL
AIR FREIGHT ASSOCIATION
BEFORE THE COMMITTEE ON FINANCE
UNITED STATES SENATE

UNITED STATES CUSTOMS SERVICE PROPOSAL FOR USER FEES

September 11, 1985

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Statement of Stephen A. Alterman
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STATEMENT OF POSITION

The Air Freight Association is a nationwide trade organization consisting of a major segment of the United States air cargo industry, including both airlines and air freight forwarders. A current Association membership roster is attached hereto. As substantial users of the United States Customs Service, the members of our industry are concerned that the proposed imposition of Customs Service user fees is unwarranted as a general proposition and will subject the industry to unwarranted and unfair double taxation.

THE USER FEE CONCEPT

President Reagan, in his fiscal year 1983 Budget Message, stated that: "In cases where the general public is the recipient of the benefits of a Federal program, rather than a clearly indentified group, users fees will not be imposed." This position was seconded by the General Accounting Office in early 1985 when it stated with specific reference to Customs user fees that: "GAO does not believe there is merit is assessing user fees for the formalities that are not voluntary because these formalities protect the nation as a whole." Comptroller General, Compendium of GAO's Views of the Costs Saving Proposals of the Grace Commission, GAO/OGC 85-1, February 19, 1985. In short, while our Association supports attempts to reduce the mounting Federal deficit, we agree with the President and GAO that this reduction should not be accomplished by subjecting a specifically targeted segment of the population to double taxation. All Americans already pay for government services such as Customs through the general income tax, and the airlines and their customers should not be made to pay twice for these services. Yet, this double taxation is precisely what the proposed user fees would accomplish.

If anyone ever proposed to charge taxpayers a fee in addition to the income tax for the processing of returns, the public outcry would be loud and immediate, and the chances of Congressional passage of any such legislation would be virtually non-existent. Yet, the imposition of Customs Service user fees would result in the same unfair situation. Like the Internal Revenue Service, the Customs Service benefits the population as a whole by monitoring imports to insure that contraband goods are not brought illegally into the country; by collecting duties on imported goods; and by protecting American labor from destructive competition nad discrimination. Indeed, it is estimated that the Customs Service generates over $20 for each dollar spent. To impose a user fee on top of this structure is singularly inappropriate.

SPECIFIC USER FEE CONCERNS

Moving beyond the general concept of user fee legislation, the members of the Air Freight Association would like to take this opportunity to discuss the propriety of certain specific user fee proposals. First, it should be noted that the air freight industry, as opposed to the passenger transportation business, has specific concerns not usually addressed in analyses of the air transportation industry as a whole. For too long, proposals nominally designed to affect the airline business generically have in fact been passenger proposals -- with the freight industry thrown in for good measure. The result of this institutional attitude has been generally to ignore the specific concerns of the freight industry; to key only on the more visible passenger segment of the market; and thereby to create an atmosphere whereby the air cargo business pays a disproportionate share of the business of regulating the airlines. Congress should not permit this attitude to continue.

With respect to user fees, one specific proposal has been to charge a fee based on the value of the shipment being imported. Even if user fees were generally appropriate, basing a fee on the value of the shipment makes no sense whatever and again subjects the air cargo industry to an unfair burden. If a user fee is designed to reimburse the government for services performed, it should be obvious that it takes the Customs Service the same amount of time to inspect a valuable 2'x 2' package as it does to inspect the same size package filled with inexpensive imports. The value of the shipment if irrelevant, and basing a "user fee" on value is blatantly unfair and discriminatory and will inevitably force the cargo industry in effect to subsidize the Customs Service. Therefore any legislation which proposes to impose a "value test" must be immediately discarded.

Moreover, it is the position of our Association that, if user fees are enacted, the administration of the collection of these fees should be as simple as possible and should not require a self-contained bureaucracy which would reduce the net benefit of such fees. It makes little sense to enact a scheme whose revenue - generation is substantially reduced by administrative costs. Therefore, if any fees are to be imposed, they should be simple. Indeed, although opposed to the underlying concept of user fees, the Association would not actively oppose enactment of legislation substantially similar to that favorably reported by the Committee on Ways and Means of the House of Representatives as H.R. 3034. This legislation would replace all customs fees with a $5 per passenger levy to be collected by the airlines ($1 for transborder and certain Caribbean Island flights) and transmitted to the U.S. Treasury on a quarterly basis.

CONCLUSION

While the Air Freight Association understands and desires to cooperate in attempts to reduce the current federal deficit, we do not feel that a Customs Service user fee is an appropriate or fair means of accomplishing this objective. Unlike most other Government agencies, the Customs Service already more than pays for itself, and the idea of the airlines industry alone paying for a service required by the general public welfare is wholly unfair and constitutes little more than double taxation. At the same time, the Association will not oppose legislation which mirrors H.R. 3034 already favorably reported by the House Ways and Means Committee.

Thank you for the opportunity of presenting the position of the air freight industry. If this Committee has any questions or needs further data, we look forward to working with you.

Air Freight Association

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MEMBERSHIP LIST - JUNE 1985

Air Express International	Darien, Connecticut
Airborne Express	Seattle, Washington
Amerford International	Jamaica, New York
American Airlines	Dallas, Texas
Arrow Airways	Miami, Florida
Associated Air Freight	New Hyde Park, New York
Aviation Group	Raleigh, North Carolina
Burlington Northern Air Freight	Irvine, California
Dynamic Air Freight	Dallas, Texas
Emery Worldwide	Wilton, Connecticut
Evergreen International Airlines	McMinnville, Oregon
Flying Tiger Line	Los Angeles, California
Imperial Air Freight	Newark, New Jersey
InterState Airlines	Ypsilanti, Michigan
Northern Air Cargo	Anchorage, Alaska
Pilot Air Freight	Lima, Pennsylvania
Profit Freight Systems	Atlanta, Georgia
Purolator Courier	New Hyde Park, New York
Ryan Aviation	Wichita, Kansas
SMB Stage Lines	Dallas, Texas
Southern Air Transport	Miami, Florida
Spirit of America Airlines	Burlingame, California
Summit Airlines	Philadelphia, Pennsylvania
Surfair	Atlanta, Georgia
Transamerica Airlines	Oakland, California
WTC Air Freight	Torrance, California

AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS

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STATEMENT

of the

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

on

EMERGENCY MEDICAL CARE AND PATIENT TRANSFERS

to the

SENATE FINANCE COMMITTEE

September 11, 1985

The American College of Emergency Physicians (ACEP) is a national medical specialty society that was founded in 1968 to further the discipline of emergency medicine. ACEP's membership now includes more than 11,000 emergency physicians who practice their specialty in emergency facilities throughout the United States. Each year, more than 77 million visits are made to emergency facilities by patients who depend upon the specialized training and expertise of emergency care providers to stabilize and treat virtually every type of serious illness and injury. Emergency physicians constitute the front-line of American medicine and, in many instances, they are effectively the only outpatient health care providers to a substantial portion of the nation's poorest citizens.

The United States Congress is currently considering the enactment of legislation which would regulate the provision of emergency medical services on a national basis. Section 124 of the Medicare Budget Reconciliation Amendments of 1985 (Title I of the Deficit Reduction Amendments of 1985 [H.R. 3128]) sets forth certain requirements and procedures to be followed by Medicare provider hospitals with respect to the provision of emergency medical treatment and imposes criminal penalties for the knowing violation of the section's requirements.

In general, ACEP believes that the objectives of Section 124 (proposed section 1867 of Title XVIII) in attempting to prevent the arbitrary transfer of patients who may suffer serious medical consequences as a direct result are laudable. There can be no question but that the health and safety of each patient is of paramount importance and that no patient should be denied access to emergency medical treatment simply because he or she may lack the ability to pay. ACEP has consistently emphasized the responsibility of all physicians to adhere to the highest standards of medical care and ethics and to contribute to the health care needs of the medically indigent. Emergency physicians in particular have discharged their obligations in this regard with the utmost attention to the professional standards of their discipline and the public interest.

ACEP is very concerned, however, with the means proposed by Section 1867 for discouraging inappropriate transfers and most particularly with the criminal sanction provisions set forth at Section 1867(d)(4). In general, Section 1867 provides insufficient guidance to physicians and other responsible medical personnel as to their duties and obligations under the law, and its enactment may unintentionally result in the imposition of harsh criminal penalties on physicians who have fully conformed to the highest standards of medical ethics in the treatment of patients with emergency medical conditions. In addition, ACEP believes that the practical effect of the law's application may be actually to reduce the quality and availability of medical services to the poor and to raise health care costs generally, results which were not in the contemplation of Section 1867's sponsors.

As a consequence, ACEP believes that the enactment of Section 1867 as currently formulated would be highly inadvisable. ACEP's specific concerns with this legislation can be grouped into the following categories:

1) The subject of inappropriate patient transfers can best be dealt with as a part of the larger issue of indigent health care generally. Patient transfers are only one aspect of this overall problem which deserves the attention and consideration of the Congress.
2) A variety of effective mechanisms already exist for discouraging transfers which may endanger a patient's health or well-being, and the civil and criminal sanctions embodied in Section 1867 are therefore largely redundant.

3) In practice, the implementation of Section 1867's requirements may lead to a host of interpretive difficulties which may result in its unfair application in individual instances and in a general degradation of medical practice and emergency health care.
4) Acceptable and effective alternative solutions exist which could reduce the incidence of inappropriate patient transfers while preserving the independence and professional integrity of the treating physician.

It is not ACEP's position that appropriate legislation cannot be formulated to deal with some of the problems associated with patient transfers. ACEP believes, however, that the subject is a complex one, that its nature and dimensions vary widely among localities and that a comprehensive solution cannot be arrived at in isolation without addressing the broader issues of indigent health care and its overall financial requirements.

1) Indigent Health Care. No one understands the full dimensions of indigent health care needs in the United States or the degree to which those needs are being met. There are no comprehensive data on the subject and only fragmentary analysis

of the impact of indigent medical care requirements in specific communities.

We do know, however, that recent changes in the health care industry have probably affected the delivery of medical services to the poor in an adverse fashion. The rapid introduction of competitive forces into the delivery of health services during the past few years has made it increasingly difficult for the private sector to absorb the costs of uncompensated care. Most notably, the implementation of the Prospective Payment System for Medicare reimbursement has exerted significant downward pressures on all hospital charges, eliminating the margin that used to be available for other purposes including the financing of indigent health care.

In addition, both consumers and third-party payors throughout the United States have become increasingly cost-conscious, and organized health care coalitions and new forms of group medical coverage such as preferred provider organizations and HMOs have reduced hospital utilization rates and cut average patient lengths of stay.

There is also a decreasing emphasis upon the provision of inpatient hospital services generally. Alternative health care delivery systems such as ambulatory surgical centers, free-standing emergency facilities and outpatient services of every sort have served to reduce hospital operating revenues and further limit the resources available for treatment of the poor.

The net effect of these developments has been to raise serious challenges to the continued financial viability of many hospitals. Some have already been forced to close; others can be expected to do so in the coming years. The impact in terms of indigent health care has been to make it even more difficult for the private sector to absorb the costs of uncompensated medical services. Despite this fact, America's community hospitals have continued to contribute their fair share: it has been estimated that the value of uncompensated hospital services rendered to the poor exceeds $6 billion annually.

It is within the context of these sweeping changes in the health care industry that the issue of patient transfers must be considered. Realistically, the economic pressures generated by new competitive forces have increased the incentives to transfer patients to publicly-supported facilities where those patients may be eligible to receive free or reduced-cost medical care that is subsidized by tax revenues. Many private hospitals no longer have the option of admitting stabilized indigent patients to their facilities in every instance inasmuch as the fiscal stability of most hospitals has been undermined without providing an alternative source of funding for indigent health care costs.

Indeed, many public hospitals throughout the United States readily acknowledge the public nature of their responsibilities and accept indigent patients from private institutions as a matter of course. The overall prevalence and impact of indigent patient transfers from private to public institutions, however, is unknown. Much attention has recently been focused upon the anecdotal experiences of a few large public hospitals in major cities where it may well be the case that transfers are becoming a serious problem. There is reason to believe, however, that the nationwide incidence of inappropriate transfers is relatively slight and that many public hospitals are entirely able to accommodate patient transfers with no serious repercussions.

It is important to note, in this context, that an individual patient may be safely and appropriately transferred for a variety of reasons, not all of which are related to that patient's medical needs. It is not unusual for patients to be transported over long distances (occasionally across continents) with no perceptible risk to the patient involved. Patients may request to be transferred because they belong to pre-paid health plans which require their hospitalization in certain designated institutions. Patients may prefer to be hospitalized in a facility with which they have established a pre-existing relationship, because their personal physicians or medical records may be located at a different hospital, or because they simply wish to avoid the inconvenience and expense of an extended stay at a facility which is inconvenient or distant from their residence, family or friends.

In this regard, a patient's concern with the avoidance of debt likely to be incurred as a result of hospitalization at a private facility should not be discounted. While a patient's desire to seek admission to a public hospital may be motivated by economic concerns, ACEP believes that such a decision can be a legitimate one when free medical services are available and that the patient's preferences in this regard should be respected. Indeed, no medical facility can purport to retain a patient contrary to that patient's expressed intention to refuse treatment and seek admission elsewhere. In such a circumstance, a medical facility has no choice but to assist the patient in arranging a safe transfer once it is clear that the patient's condition will not be adversely affected as a result.

The central point is that the subject of patient transfers is a subtle and complex issue whose full dimensions are not clearly understood. It is not a topic which is susceptible to quick and universal solution. ACEP is concerned, however, that Section 1867, by mandating a nationwide regime of transfer standards enforced with criminal penalties, may inadvertently result in the exascerbation of the very situation it seeks to remedy.

In particular, ACEP fears that the enactment of Section 1867 may serve to discourage patient transfers under almost all circumstances. Faced with the prospect of substantial fines and possible imprisonment, many physicians may be understandably reluctant to authorize a transfer even when there may be a medical justification or when the patient has specifically requested to be transferred. The incentives to practice "defensive medicine" will become all the more compelling with the threat of criminal sanctions, and the consequent impact on health care costs generally may be unfortunate.

ACEP would consider such a development to be inconsistent with the standards of medical care and ethics and the goal of efficient health care delivery that it supports. This is particularly true inasmuch as ACEP believes that there are already existing mechanisms which strongly discourage inappropriate patient transfers in almost all cases.

2) Existing Disincentives to Inappropriate Patient Transfers. ACEP is troubled by the implicit assumption of Section 1867 that severe criminal penalties are necessary to prevent physicians from arbitrarily transferring seriously ill and injured indigent patients to public facilities. There is no dispute that occasionally such transfers do take place, but ACEP suspects that their incidence may have been overstated in the popular media. By and large, the vast majority of physicians

take their ethical responsibilities very seriously and render a significant amount of medical care without regard to a patient's ability to pay. Emergency physicians alone render an estimated $300 million in uncompensated medical services each year.

In addition to each physician's personal ethical standards, the subject of patient transfers has been addressed by a number of professional medical organizations. Both the American Hospital Association and the Joint Commission on Accreditation of Hospitals have guidelines relating to this area. A hospital which allows inappropriate transfers risks the possible loss of its accreditation. The American College of Emergency Physicians has itself recently adopted revised guidelines concerning patient transfers from emergency departments, and a copy of those guidelines accompanies this statement.

Of more immediate impact to the individual physician is the ever-present threat of liability in tort. It is now well established that a physician who authorizes a transfer which endangers a patient's life or health may be sued as a result for medical malpractice. Typical of recent cases in this area is Thompson v. Sun City Community Hospital, 141 Ariz. 597; 688 P.2d 605 (1984), in which the Arizona Supreme Court held that an aggrieved patient could recover from a hospital for any damages sustained as the result of an improper transfer.

The specter of malpractice liability has profoundly affected the practice of medicine in recent years. Most physicians are at least cognizant of the potential legal risks associated with virtually all medical procedures and some have accordingly adopted extremely conservative diagnostic and treatment modalities. The result has unfortunately exerted some pressure on health care costs throughout the nation, and the recent tendency of juries to award large verdicts in malpractice cases has dramatically increased insurance premiums. Annual malpractice insurance premiums in obstetrics and some surgical specialities now approach $100,000 in some states, and the availability of coverage for some disciplines is increasingly in doubt.

Faced with mounting insurance costs and the increasing prevalence of patient lawsuits, some physicians have reluctantly decided to abandon or restrict their practices. There can be no question but that physician accountability through the legal system has improved, but it has not been without cost. ACEP is concerned that the introduction of criminal penalties as an additional sanction for physician error may accelerate the departure of some physicians from the profession altogether and otherwise increase costs to the public at large.

From its perspective as the representative of the nation's emergency physicians, ACEP considers the existing disincentives to improper patient transfers to be sufficient. It is almost inconceivable that any emergency physician or hospital would knowingly run the substantial risks of civil liability that would result from a decision to transfer a patient contrary to that patient's best medical interests. ACEP acknowledges the fact that inappropriate transfers are, however, sometimes made. The existing legal system and the profession's standards of conduct, however, are capable of rectifying those mistakes when they occur and ensuring a just compensation for any patient who may suffer as a consequence.

3) Practical Problems in Implementing Section 1867. In addition to ACEP's belief that Section 1867 provides for remedies that may not be necessary or that may be counterproductive in operation, ACEP is concerned by the section's lack of definitive guidance as to the precise conduct prohibited. In general, the implicit premise underlying Section 1867 is that medical diagnosis is an exact science, susceptible in every case to precise, retrospective evaluation. Such, unfortunately, is not always the case. Emergency physicians, in particular, are often called upon to make rapid, difficult decisions concerning a patient's treatment which may include judgments as to the medical advisability of a transfer to another facility. Not every physician may agree in all instances as to the proper course of

treatment, but the existence of professional disagreement does not necessarily indicate sub-standard care.

The difficulty with Section 1867 is that it is non-discriminating in its application. Physicians may face the prospect of imprisonment and fines despite the fact that they have rendered the best possible care under the circumstances. The test of "gross deviation from the prevailing local standards of medical practice" as set forth in Section 1867 is inherently capable of a variety of interpretations.

Most disturbing is the fact that Section 1867 will, in fact, be interpreted and enforced not by medical peers but by U.S. Attorneys. ACEP believes that the interjection of non-physician review of the most intimate diagnostic decision-making is not only inadvisable as a matter of policy but contrary to the admonition of Section 1801 of the Medicare Act, 42 U.S.C. § 1395, that "[n]othing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided..."

Further, the practical operation of Section 1867 in many cases will be to place emergency physicians in the intractable position of having to provide extended care to emergency patients who might encounter some risk in transport. Most emergency physicians do not have admitting privileges in the hospitals where they practice. Should an emergency physician be unable to locate a staff doctor willing to admit and accept responsibility for the treatment of a patient, the emergency physician will then be faced with the impossible choice of either transferring the patient and risking eventual prosecution or retaining the patient in the emergency department, effectively on an inpatient basis.

Section 1867 will have a particularly harsh impact on the nation's small and rural medical facilities. Many hospitals of this sort operate emergency departments, but many of them are not fully staffed by physicians on a twenty-four hour basis and depend instead upon the services of skilled nurses who initially evaluate the patient's condition and on physicians who are on call outside the hospital. These hospitals sometimes provide the only first-aid and life-saving facilities in their communities, but they will be particularly vulnerable because of their limited resources to inadvertent violations of Section 1867's requirements. A physician who is not physically present in such an emergency department but who is nonetheless on call and a "responsible physician" as defined in Section 1867(d)(4)(B) will be confronted with the prospect of criminal sanctions if he or she should authorize a patient transfer because it appears to be in the patient's best medical interests in light of the resources available at the transferring hospital at the time the patient is seen.

In addition, it is not clear from the language of Section 1867(a) what "an appropriate medical screening examination" is or who is required to provide it. The practice of emergency medicine has undergone considerable change in the past decade as new delivery systems such as regional trauma centers and areawide telecommunications networks have evolved for the purpose of directing patients to the nearest appropriate medical facility as quickly as possible. It is sometimes the case that preliminary evaluations of a patient's condition must take place on an urgent basis and occasionally by means of radio contact with rescue units on the scene. The requirement of providing a complete medical screening examination prior to transfer may simply be impossible to fulfill in all circumstances and may often be contrary to the patient's best medical interests in obtaining prompt medical attention at the most appropriate facility.

ACEP is also concerned by the requirement of Section 1867(c)(2)(A)(ii) that the agreement of the receiving facility be obtained in all circumstances before a patient transfer is initiated. There have been instances in which non-physician administrative personnel at some medical facilities have intervened to block or countermand patient transfers already agreed upon between responsible physicians. It is ACEP's position that a decision as to the medical advisability of any transfer is a medical determination to be made by the physicians on the scene and that administrative concerns should not interfere with that process. Just as the transferring hospital has a responsibility to conduct a patient transfer in a safe and appropriate manner, so too does the receiving hospital have a responsibility not to refuse a transfer arbitrarily when otherwise indicated.

ACEP believes that the civil enforcement provisions incorporated at Section 1867(d)(3) may potentially serve only to aggravate relations among hospitals in particular localities. The inclusion of "any entity" among those eligible to claim damages as a result of an inappropriate transfer may lead to the unfortunate spectacle of hospitals bringing suit against each other over patient transfer disagreements. The resolution of individual transfer situations can often best be handled on a more informal basis; the judicial system is particularly ill-equipped to mediate such disputes.

Further, ACEP is in doubt as to the potential implications of Section 1867(d)(3)'s stipulation that an action for damages may be brought "in an appropriate court of general jurisdiction of the State in which the hospital is located or in the appropriate Federal district court." This provision may simply be an acknowledgment that certain actions will inevitably be filed in the federal courts as a part of their diversity of citizenship jurisdiction. It may, however, also be interpreted to create a new federal question basis for district court jurisdiction over cases arising out of Section 1867. If the latter, the result will be federal court adjudication of what are essentially medical malpractice cases now handled almost exclusively in state courts.

At the very least, ACEP doubts whether it is appropriate to provide for equitable sanctions in addition to the fines and other penalties already set forth in Section 1867. Each patient must necessarily be evaluated and treated on an individual basis, and it is not likely to be the case that separate patient transfers will share many of the same characteristics. Nonetheless, if injunctive relief is entered to restrain future patient transfers, it will be very difficult for a court to frame such an order and for an affected hospital or physician to know precisely what conduct has been restrained. The inevitable result may be continuing judicial supervision of on-going medical decision-making, the kind of active judicial management of technical issues which most courts are reluctant to undertake.

The inherent ambiguity in many of Section 1867's provisions is illustrated by the definition of "to stabilize" as set forth in Section 1867(e)(4)(A). That definition stipulates that emergency medical treatment must be provided to a patient sufficient "to assure" that the patient's condition will not likely deteriorate as the result of a transfer. The practice of medicine is not, however, an exact science, and rigid guarantees and assurances as to the probable course of any illness or injury are simply not within the capacity of any physician to provide.

4) Alternative Solutions. ACEP strongly believes that the subject of patient transfers and emergency medical care in general is sufficiently important to warrant careful and deliberate study by the Congress. The text of Section 1867 originated with the House Ways and Means Committee's deliberations on the Deficit Reduction Amendments of 1985, and no public hearings on Section 1867 have yet been held. The actual text of this legislation has been publicly available for only a few weeks. There is thus the distinct possibility that the bill may be enacted with virtually no opportunity for public comment and within the space of less than two months from start to finish.

Section 1867 is, however, a dramatic and controversial addition to federal law. ACEP believes that this legislation deserves careful and considered attention with an opportunity for the Congress to receive and evaluate the opinions of interested persons and organizations. It should not be enacted in haste as a part of the annual budget process.

Accordingly, ACEP would respectfully suggest that Section 1867 be severed from H.R. 3128 so that its merits and probable impact on American medicine can be separately evaluated. The subject is far too important to be resolved by the enactment of criminal penalties as the panacea for a situation which is inadequately understood.

In this regard, ACEP would support legislation directing the Secretary of Health and Human Services to undertake a comprehensive study to determine the scope and dimensions of indigent health care needs in the United States. Such a study would constitute an invaluable contribution to our understanding of an important aspect of American health care. There is insufficient information on the degree to which the medical requirements of the poor are now being met, and it is time that a careful analysis be conducted of the impact on indigent health care of recent changes in the health care industry. One part of this study could appropriately be devoted to an examination of the incidence and effects of patient transfers.

With specific regard to emergency medical treatment, ACEP supports the concept that all hospitals should be required to develop plans governing the provision of emergency medical services and setting forth the procedures to be followed when transferring a patient to another facility. If necessary, such a requirement could be included as a condition of participation for Medicare reimbursement. The objective would be to ensure that every patient is provided with appropriate emergency medical treatment regardless of that patient's ability to pay.

Many states now enforce such standards either through legislation or by judicial interpretation, and the enforcement of such state legislation and the adjudication of claims on behalf of aggrieved patients should continue to be matters of administrative action and civil litigation. There is very little indication that these remedies have proven to be inadequate in the past. The use of federal criminal sanctions in a field such as emergency medicine which is characterized by subjective judgment and urgent decision-making is peculiarly inappropriate. The potential penalties are draconian in degree. Not only may some physicians be faced with lengthy prison terms and substantial fines for a mistake in judgment, but their future livelihood may effectively be destroyed. Most states automatically revoke a medical license upon conviction of a felony. The addition of criminal penalties to civil liability to loss of the ability to practice medicine amounts to the sort of cumulative sanctions that are both unnecessary and extraordinarily harsh.

If enacted as currently written, Section 1867 will take effect on October 1, 1985, only days after it is likely to be signed into law. There will be virtually no time for physicians across the country to know and understand their duties under the law and the possible penalties they may encounter. ACEP believes that the goals and objectives of Section 1867 are worthy of support, but that the means proposed may unfortunately prove to be disastrous in application.

The American College of Emergency Physicians firmly believes in the right of every patient to be treated with dignity and compassion. Adequate medical care should be available to every individual, regardless of economic status. As the national professional society of emergency physicians, ACEP will continue to support measures designed to strengthen and improve the provision of emergency medical services and to attain the goal of a society in which access to medical care is available to every person in need. Inappropriate patient transfers are only one manifestation of the fact that America has not yet reached that goal. A resolution to this issue can be found, but it must be a solution which combines concern for the rights and dignity of the individual patient with an appreciation for the difficult and demanding challenges of the profession of emergency medicine.

The American College of Emergency Physicians stands ready to work with the Congress in formulating a reasonable and effective solution to this important issue.

AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS

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Policy Statement on Transfer of Patients *

From time to time, patients in an Emergency Department are transferred to other facilities. The transfer may be to another Emergency Department or directly to an inpatient facility. Clearly, not all physicians or medical facilities have the capabilities to care for every patient. At times, patients, or those responsible for them, request transfer to another facility for various reasons (which may or may not be medical); at times patients are transferred to receive the benefit of more appropriate facilities and/or services than are available in the given hospital or Emergency Department; and at times patients are transferred because of economic considerations, which may include the availability of free or reduced-cost medical care at a public or other facility or in accordance with the requirements of pre-existing contracts for patients of prepaid health plans that stipulate which facilities patients are to use.

Patients should not be transferred to another facility without first being stabilized. Stabilization includes adequate evaluation and initiation of treatment to assure the transfer of a patient will not, within reasonable medical probability, result in death, or loss or serious impairment of bodily parts or organs.

Stabilization of patients prior to transfer should include:

1. Establishing and assuring an adequate airway and adequate ventilation.
2. Initiating control of hemorrhage.
3. Stabilizing and splinting the spine or fractures when indicated.
4. Establishing and maintaining adequate access routes for fluid administration.
5. Initiating adequate fluid and/or blood replacement.
6. Determining that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion. The vital signs should remain within these parameters for a sufficient time prior to transfer to be reasonably certain they will not deteriorate while en route to the receiving hospital. However, there may be times when stabilization of a patient's vital signs

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* Approved by the ACEP Board of Directors on August 13, 1985. These are guidelines and are not to be construed as standards of care.

is not possible because the hospital or Emergency Department does not have the appropriate personnel or equipment needed to correct the underlying process (e.g., thoracic surgeon on staff or cardiopulmonary bypass capability). In these cases, numbers 1-5 of the above should be performed and transfer carried out as quickly as possible.

At times, a patient or those responsible for the patient, may request a transfer that seems medically inappropriate. The physician is obliged to explain the medical risks involved, and an informed consent should be signed by the patient (or those responsible for the patient such as a parent or guardian) and the physician. In the event of such a transfer, the physician should still use every resource available in an attempt to stabilize the patient prior to transfer.

The following guidelines should be observed for transfer of patients:

1. The patient should be transferred to a facility appropriate to the medical needs of the patient. The facility should have adequate space and personnel available to care for the patient.

2. A physician or other responsible person at the receiving hospital must agree to accept the patient transfer prior to the transfer taking place. Acceptable "other responsible persons" should be medical personnel who are designated by the hospital and given the authority to accept the transfer of the patient. The patient transfer should not be refused by the receiving hospital when the transfer is indicated and the receiving hospital has the capability and/or responsibility to provide care to the patient.

3. Communication between responsible persons at the transferring and receiving hospitals for purposes of exchanging clinical information should occur prior to transfer. Ideally, this communication should be physician-to-physician.

4. Once a patient is accepted for transfer, an appropriate medical summary and other records (including lab results and copies of EKGs and X-rays) should be sent with the patient.

5. A patient should be transferred via a vehicle that has appropriately trained personnel and life-support equipment. At times, it may be necessary for additional specialized personnel from the transferring or receiving hospital to accompany the patient.

At times, transfer of patients occurs routinely or is part of a regionalized plan for obtaining optimal care for patients at more appropriate and/or specialized facilities. In these situations there should be:

1. Written guidelines (e.g., types of cases appropriate for transfer) to govern the transfer of patients;

2. Pre-existing transfer agreements between the facilities, and;

3. Pre-transfer communication between appropriate responsible personnel.

American College of Surgeons

FOUNDED BY SURGEONS OF THE UNITED STATES AND CANADA, 1913

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C. ROLLINS HANLON, M. D., F. A. C. S.
DIRECTOR

September 18, 1985

The Honorable Bob Packwood
Chairman
Senate Finance Committee
United States Senate
SD-219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed is the statement of the American College of Surgeons concerning the budget deficit reduction proposals H.R. 3101 and H.R. 3128 that are being considered in the House of Representatives. We request that this statement be made part of the record of the Senate Finance Committee's public hearings on budget reconciliation held on September 11, 12, and 13.

The American College of Surgeons is a voluntary educational and scientific organization devoted to the ethical and competent practice of surgery and to the provision of high quality care for the surgical patient. The College provides educational programs for its more than 47,000 Fellows and others in this country and abroad, establishes standards of practice, disseminates medical knowledge, and provides information to the general public.

ASSISTANTS AT OPERATION

Both H.R. 3101 and H.R. 3128 include provisions stating that Medicare no longer pays for assistants at operation for cataract operations. Moreover, both bills state that the Secretary of the Department of Health and Human Services (HHS) should develop recommendations and guidelines for other procedures for which an assistant at operation is not necessary.

We believe these provisions are not in the best interest of patients and that the provisions compromise high quality surgical care under the Medicare program. Moreover, we believe it is inappropriate for HHS to prescribe standards of surgical care. We believe that the surgeon performing the operation must be allowed to exercise his or her best judgment for each patient as to the need for assistants at operation, taking into consideration the condition of the patient, the nature of the operation, the patient's past medical history, and other relevant factors.

PHYSICIAN PAYMENT COMMISSION

Both H.R. 3101 and H.R. 3128 would establish a physician payment commission to make recommendations regarding Medicare payment to physicians and to advise the Health Care Financing Administration on the development of a fee schedule based on a relative value study. H.R. 3128 mandates that such a Commission be a subcommittee of the Prospective Payment Assessment Commission (ProPAC). H.R. 3128 also charges the Commission, among other things, to "review input costs associated with provision of different physicians' services."

We strongly encourage that any commission on physician payment include adequate surgical representation. At the present time, for example, ProPAC has no members who are surgeons.

We also wish to comment on the reference to "input costs" or resource costs in H.R. 3128. It is worth noting that the principal investigator of the only study to date on resource costs has acknowledged that his study contains as much as 50 percent error. It does not seem prudent to give credence in legislation to a concept that has been the subject of only one study, especially when that study does not meet accepted research standards.

In lieu of the resource cost approach, the College supports the concept of a complexity/severity index to assess physicians' services. Preliminary research on this concept is being conducted at Boston University Health Policy Institute. We would be pleased to provide additional information on the complexity/severity index upon request.

MANDATORY SECOND SURGICAL OPINION PROGRAMS

Mandatory second surgical opinion programs have not been endorsed by this College; our comments on these programs have been circulated to members of Congress on numerous previous occasions. Our comments in this letter are restricted to provisions in H.R. 3101.

H.R. 3101 states that the Secretary of HHS will specify not only the procedures that require second opinions, but also the types of board certified or board eligible specialists who must be consulted for a second surgical opinion. We believe this provision sets up an inappropriate role for the Secretary of HHS. Furthermore, the language of H.R. 3101 does not make clear that the specialists to be consulted are surgical specialists.

H.R. 3101 also specifies that peer review organizations (PROs) be used as referral centers for patients seeking second surgical opinions. We see this additional role for PROs as a potential conflict of interest. It means that PROs would be reviewing the same physicians to whom they would be referring patients.

In another provision of the legislation, PROs would be required to provide information to the physician providing the second opinion "in such form so as not to identify the physician who rendered the first opinion."

This provision conflicts with the College's firm conviction on the need for the first and second physicians to consult with each other. Denying physicians the opportunity to consult with each other is another way of compromising medical care under the Medicare program.

Finally, imposing civil monetary penalties on physicians if they fail to inform patients of the need to obtain a second surgical opinion is an unacceptable provision. It is particularly onerous in light of the fact that second surgical opinion programs are of questionable value and have not achieved widespread support among physicians.

The American College of Surgeons appreciates the opportunity to comment on these provisions of H.R. 3101 and H.R. 3128. We respectfully request that our comments be given serious consideration.

Sincerely,

C. Rollins Hanlon, M.D., F.A.C.S.

SEPT:D

AMERICAN FOUNDATION FOR THE BLIND, INC.

United States Senate
Committee on Finance

Hearings on Deficit Reduction
September 11, 1985

Statement of Barbara D. McGarry
Department of Governmental Relations
The American Foundation for the Blind

As the national voluntary research and consultant agency in the field of services to blind persons of all ages, the American Foundation for the Blind welcomes this opportunity to submit our recommendations on a specific area of deficit reduction already receiving national attention - the issue of skyrocketing costs, both to the patient and to the Medicare program, of cataract surgery.

Because "Cataract surgery is the most frequent procedure performed on the Medicare population in the United States today," in the words of the Inspector General of the Department of Health

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and Human Services (HHS), we have reviewed the problems presented, the legislative remedies offered, and we summarize our 6 recommendations as follows:

Summary of recommendations:

(1) Before submitting to cataract surgery, a Medicare-eligible patient must be required to obtain a second, independent medical opinion on its advisability and cost.

(2) If medical opinions concur that cataract surgery will be uncomplicated by any pre-existing condition of the patient, Medicare reimbursement should not be available for an assistant surgeon for a routine procedure.

(3) If cataract surgery includes implantation of intraocular lenses (IOL), Medicare reimbursement for such lenses should be within guidelines issued by the Secretary of HHS. For post-cataract patients for whom cataract eyeglasses or cataract contact lenses are prescribed, Medicare reimbursement should be limited to the replacement only once every year of lost or damaged cataract eyeglasses; or, in the first year after surgery, for one original cataract contact lens for each eye, and for the replacement only twice of a lost or damaged lens for each eye. Whatever the method of replacement for the natural lens, there should be separate determinations of the payment amount for the replacement lens (IOL, contact, or glasses) and of the payment amount for professional services.

(4) Medicare reimbursement for outpatient cataract surgery should be limited to the lower of the amount paid to an ambulatory surgical center or the in-hospital rate under DRG-39 (Diagnosis Related Group for Lens Procedures).

(5) The Congressional Office of Technology Assessment should develop an annual review of advances in technology for surgical implantation of artificial devices, with recommendations for altering Medicare payments to reflect these advances.

(6) The Senate should add its approval to House-passed legislation that will help restore the Medicare patient's confidence in the specialist performing his or her cataract surgery.

I. Second opinion.

Ethical practitioners have always urged their prospective surgical patients to seek a second, independent, medical opinion on the need for a particular surgical procedure. Not only is this in the patient's best interest, but in our litigious society it is to the surgeon's own interest as well. We are therefore pleased to see this provision mandated for all Medicare patients, in legislation reported by the House Energy and Commerce Committee (H.R.3101, section 106); our only concern with the wording is that it must sufficiently stress the need for a truly independent second opinion, based on the patient's choice rather than the surgeon's referral. The new "Second Surgical Opinion Program" sponsored by the Department of Health and Human Services, offers a toll-free number (800-638-6833) to refer the caller to accredited surgeons in the caller's area with expertise in the special area of surgery contemplated.

II. Assistant Surgeon.

The above-mentioned pending legislation, as well as the Deficit Reduction bill reported by the House Ways and Means Committee (H.R. 3128, Section 147), both prohibit Medicare reimbursement for an assistant surgeon in routine cataract surgery, where the patient's pre-op condition reflects no complications likely to be exacerbated by the surgery. In addition, the June 7, 1985 report of the Inspector General of the Department of Health and Human Services documents the widely-varying charges to Medicare for this service, with the conclusion that "Although the ophthalmologists require assistance during cataract surgery, such assistance is frequently provided by a surgical technician and/or operating-room nurse." Because of greatly improved surgical techniques which have reduced actual operating time from 3 hours to less than 30 minutes, we agree with the Inspector General's recommendation to "exclude the services of an assistant surgeon from Medicare coverage for routine cataract surgery," and with his additional recommendation "to provide coverage for an assistant surgeon where special medical conditions exist." Such conditions, of course, can be identified more easily by the availability of a second opinion as to the need for such surgery.

III. Replacement (prosthetic) lenses for the Cataract Patient.

All the references cited above, plus the findings of the January 10, 1985 report of the U.S. General Accounting Office (GAO) stress the need for uniformity in Medicare payments for a replacement lens provided the cataract surgery patient. The current wide disparity in lens costs charged to Medicare is documented in the Inspector General's report dealing mainly with surgically implanted intraocular lenses (IOL's); while the GAO report deals mainly with contact lenses or cataract glasses, equally subject to overcharge or abuse. In one instance cited by GAO testimony before the House Ways and Means Subcommittee on Health, on August 1, 1985, "one [Medicare] carrier paid a physician for 40 lenses in 20 months for one Medicare beneficiary." We are pleased to note that proposed limitations on reimbursement for prosthetic lens were published by HHS in the August 16 Federal Register.

We agree with all these authorities that costs for replacement lenses, whether IOL's, contact, or eyeglasses, should be separately identified in bills presented to Medicare. Further, we think the rate of additional replacements should be subject to medical justification by the prescribing ophthalmologist, with strict HHS scrutiny mandated. We feel the replacement rate recommended by GAO is"inherently reasonable";it is also more generous than the rate recommended by the American Academy of Ophthalmology (AAO) which perhaps has reacted hastily to the nationwide publicity on this issue. In an evident effort to distance itself from the target of this publicity, the American Medical Association has issued a policy statement emphasizing that a physician is not a commercial enterprise and "should not profit from the resale of products or from the work of others." Regrettably, because the AMA or AAO have not seen fit to enforce their own standards of ethics, remedial legislation is necessary.

IV. Outpatient cataract surgery reimbursement.

Before 1981, cataract patients' surgery was almost always performed in-hospital, requiring a three-day stay with the patient immobilized. However, the last four years have seen a revolution in cataract surgery techniques, whereby most patients now do not need to be hospitalized at all. Today, 90 percent of all cataract surgery involves the implantation of intraocular lens; and, with greatly expedited surgical extraction of the natural clouded lens, the whole surgical procedure can be accomplished under local anaesthetic, in an outpatient setting, in less than an hour. The total patient time required, including pre-op and post-op, can be less than 3 hours. Naturally, the elderly patient would prefer this simpler, non-incapacitating procedure. Consequently, between 850,000 and 900,000 Americans, most of them elderly, will have had a cataract removed this year, with that number expected to top 1,000,000 by next year. As the Senate Appropriations Committee has stated in S.Rpt. 98-544,

> "Most of the major eye problems that we face today in this country are aging-related. In the next 50 years there will be a 100-percent increase in the size of the American population over age 55 and a 150-percent increase in the number of those over 85."

Keeping in mind these demographic projections, the Committee's report commends NIH's prestigious National Eye Institute for pioneering research in senile cataract and other unhappy concomitants of aging.

While this research was going forward, Congress enacted and the Secretary of HHS implemented a new method of health cost controls (the Prospective Payment System) applied to Medicare in late 1983. These PPS controls applied only to in-hospital Medicare patients, however. As a result, in the words of a Congressional witness at the August 1, Ways and Means hearings,

> "Improved cataract surgical techniques and hospital cost containment have contributed largely to a shift from the hospital to an outpatient setting ... One would think that savings would accrue to the Medicare Program by eliminating hospital stays and the attendant services which accompany the stay. This has not been the case."

With the last sentence acknowledged as something of a masterpiece of understatement, its author, Representative Claude Pepper, adds,

> "We found that roughly half of the nation's $3.5 billion annual bill for cataract surgery is lost to fraud, waste, and abuse. Losses to the Medicare program alone will total over $1.5 billions this year."

To apply controls only to a part of a system, of course, is to invite exploitation of the uncontrolled part. In order to remedy the situation, Representative Pepper's bill, H.R.3061, would "cap" outpatient cataract surgery reimbursement by Medicare, by limiting the amount paid at either the hospital DRG-39 rate or the ambulatory surgical center payment - whichever is lower. In the Senate, an even broader approach has been taken by Senator David Durenberger's bill, S.1489, which would impose a Prospective Payment System on all outpatient surgery reimbursed by Medicare. While we enthusiastically commend the thrust of H.R.3061, a review of the July 31, 1985 HHS report on the nation's annual health care costs persuades us that the broader approach is necessary. The HHS report documents a dramatic drop in hospital - based health care costs since imposition of Medicare's Prospective Payment System; but a 15 percent increase in dentists' bills (dental surgery is reimbursable by Medicare), a 10.2 percent increase in doctors' charges, and a 9.4 percent increase in prescription drugs.

V. Annual Review of Surgical Technology Advances.

Following his committee's two-year investigation into cataract surgery practices, Representative Pepper introduced not only H.R. 3061 as outlined above, but also another bill, H.R.3119, so that Congress would be better able, on an annual basis, to determine reasonable charges. In his introductory remarks, Mr. Pepper observed,

> "This would keep Medicare payments in line with rapidly changing technology and skills. Having no formal mechanism to do this has resulted in unreasonable and wasteful reimbursement. For example, the fee paid to [cataract surgery] physicians is now around $1200. This rate was established prior to 1981 when the procedure took 3 hours. Now a surgeon can perform the same surgery in 20 to 30 minutes, but Medicare has not altered payments."

Although the pending House bills on deficit reduction provide varying mechanisms for technical review, only H.R.3119 requires the Congressional Office of Technology Assessment to conduct such a review, independently from possible Departmental pressures. We feel such independence guarantees an objective assessment, with the mandated annual review a long-overdue component of reasonable cost control.

VI. Restoring Patient Confidence.

The investigations cited above have offered incontrovertible proof of what may be fairly described as the biggest mass exploitation of blind people in American history. As a result, the prospective cataract surgery patient, having been exposed to the national publicity resulting from the investigations, is bound to suffer from uncertainty and a loss of confidence, not wanting to be a party to exploitation of Medicare's resources. To restore patient confidence in the integrity of medical care, we therefore advocate Senate concurrence in a House-passed bill, H.R.1868, (the Medicare-Medicaid Patient Protection bill) which will authorize the Inspector General of HHS to eliminate from the Medicare system the estimated 20 percent of cataract surgeons who have been identified as participating in unethical practices. Although our main concern is restoring patient confidence in quality care, we also feel that the remaining 80 percent of the nation's 13,508 ophthalmologists would welcome this means of vindication of their professional integrity.

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Summary:

Since its founding in 1921, the American Foundation for the Blind has recognized and encouraged the desire of all our visually handicapped citizens to join and participate in the mainstream of American society. Blind and visually handicapped citizens have perhaps a special insight into the need for a healthy national economy, since ever-increasing deficits, translated into inflated costs, invariably inflict the greatest harm on those least able to afford it - the disabled and the elderly living on fixed incomes. Our research has shown that by far the greatest number of blind and visually impaired are found in the segment of our population that is both elderly and subsisting mainly on social security payments. If inflated copayments for needed cataract surgery are required of this segment, they may simply not have the resources, with the unnecessary and unpalatable alternative of institutionalization. With adequate cost controls, both our visually handicapped citizens and our country will benefit.

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Written Comments

of

THE AMERICAN INTRA-OCULAR IMPLANT SOCIETY

RE: S.1489, "THE MEDICARE OUTPATIENT SURGERY
SAVINGS, ACCESS, AND QUALITY ACT OF 1985"

Before the
Senate Finance Committee

The Honorable Robert Packwood, Chairman

September 13, 1985

SUMMARY OF COMMENTS

The American Intra-Ocular Implant Society ("AIOIS") supports the principal aspects of the "Medicare Outpatient Surgery Savings, Access, and Quality Act of 1985," S.1489, introduced by Senator David Durenberger (I.R. Mn.) earlier this year. AIOIS agrees that a cap, at DRG levels, on standard overhead payments for hospital outpatient and ambulatory surgical center ("ASC") surgical procedures will result in significant savings to Medicare for cataract and other surgeries, and will help remedy the Medicare abuses recently identified by Congressman Claude Pepper (D. Fl.) in a published Report. See Cataract Surgery: Fraud, Waste and Abuse, A Report by the Chairman of the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, House of Representatives (July 19, 1985).

AIOIS also supports in principle the concept of peer review organization ("PRO") review of ASC and hospital outpatient surgical procedures. Traditional methods of peer review are often diminished and sometimes lacking altogether in such settings. However, specific guidelines for review must be developed in advance if PRO preadmission review or retroactive claims denial is to be fair and effective. Without such guidelines, the problems that have plagued implementation of PRO review of hospital inpatient procedures will become even more pronounced.

INTRODUCTION: AIOIS

The American Intra-Ocular Implant Society is a professional scientific and educational association made up of 4,500 opthalmologists involved with anterior segment eye surgery, including cataract extraction and intraocular lens (IOL) implantation. For over a decade, AIOIS has been at the forefront of federal government issues involving IOLs. For example, AIOIS helped achieve a legislative compromise in connection with the Medical Device Amendment of 1976 that placed IOLs under the investigative control of the Food and Drug Administration while ensuring the continued availability of IOLs to qualified physicians. Likewise, AIOIS assisted FDA in designing and implementing studies of intraocular lenses that rank as the largest studies of any medical product in history. AIOIS has provided scientific and medical expertise to FDA on numerous issues relating to the safe, effective use of IOLs. AIOIS has also worked with Medicare authorities since 1977 on federal reimbursement issues involving IOLs. In short, more than any other group, AIOIS has promoted the safe and widespread use of advanced surgical techniques and medical devices in the treatment of cataracts, helping restore or improve the visual acuity of millions of elderly Americans.

AIOIS COMMENTS ON S.1489

I. The Prospective Payment Provisions.

AIOIS endorses the proposed amendments to title XVIII of the Social Security Act (the "Act") that would establish a prospective payment mechanism for hospital outpatient and ASC surgery. Under S.1489, section 1861(v)(1)(K) of the Act would be amended to provide that Medicare will pay for facility services with respect to covered hospital outpatient and ASC procedures an amount not greater than the DRG rate for that same procedure. At the same time, S.1489 would amend section 1861 of the Act to equalize facilities payments made to hospitals and ASCs. The net result of these provisions is that Medicare payments for cataract and other covered procedures is capped at the DRG rate generally applicable under Part A of Medicare.

These proposed statutory amendments should be adopted by this Committee. First, the amendments go far towards correcting the tremendous payments imbalance now existing within the Medicare system. Congressman Claude Pepper (D. Fl.) described that imbalance as it affects cataract surgery:

> Medicare is paying . . . hospitals about $1200 under DRC 39 for [inpatient] cataract surgery with IOL implants. These same hospitals are collecting several times this amount, as much as $4500, for the identical procedure [on an outpatient basis] using only 3 hours of hospital resources.

Report of Subcommittee on Health and Long-Term Care at 25 (July 19, 1985). There is no reasonable justification for such disparate Medicare payments for identical procedures performed in different settings. As the Inspector General estimates, a savings to Medicare of $325 million per year for cataract surgery alone will result through application of this prospective reimbursement methodology. These financial savings are achieved, most significantly, without any corresponding decrease in the quality of patient care. AIOIS finds the prospective payment amendments contained in S.1489 most welcome.

The prospective payment amendments are welcome for a second reason. As Congressman Pepper demonstrates at length, the sale of intraocular lenses used in cataract surgery -- the most frequently reimbursed major surgical procedure under Medicare -- recently has been fraught with questionable marketing practices. In particular, discounts, rebates and bonuses offered by IOL manufacturers to encourage the purchase of their lenses have become increasingly prevalent. For many years, AIOIS has been concerned about the potential illegality of these discounts, rebates and bonuses, and indeed, has advised its members and IOL manufacturers in more than a dozen communications that the Medicare laws may be violated where discounts, rebates or bonuses are not reported and reflected in claims submitted by opthalmologists to Medicare. AIOIS anticipates that a cap on Medicare payments at the DRG level and related features of S.1489 will reduce substantially the incentive or opportunity for passing through such discounts, rebates or bonuses to Medicare. By so doing, the principal abuses identified by Congressman Pepper can be greatly reduced if not entirely eliminated.

II. The PRO Review Provision.

S.1489 also proposes to amend section 1154 of the Social Security Act by expanding the oversight and review responsibilities of PROs. Specifically, the proposed amendments authorize PROs to review ambulatory surgical procedures performed in ASCs and in hospital outpatient departments. PROs currently exercise the responsibility to review matters relating to hospital admissions. As a general matter, PRO review of surgical procedures conducted in Medicare-certified facilities is no less desirable -- and is in some ways more desirable -- for outpatient and ASC procedures than it is for inpatient procedures. Whereas hospitals often adopt formal internal peer review programs or other safeguards to ensure quality inpatient care, those safeguards are sometimes less prevalent in the hospital outpatient setting and occasionally nonexistent in ASC or other non-hospital surgical locations.

It is imperative, however, that specific criteria for PRO oversight review be developed in collaboration with medical specialty organizations and HCFA before the expansive PRO outpatient oversight amendments are formally implemented. The experience encountered so far by opthalmologists and others with respect to PRO admissions oversight demonstrates the necessity for, and the feasibility of, workable and specific review guidelines.

As this Committee well knows, the PRO program mandated by Congress in 1983 requires that Medicare sign contracts with private groups in each state to achieve percentage reductions in certain inpatient medical procedures, and to encourage transfer of other procedures from the hospital inpatient setting to the theoretically less-expensive hospital outpatient, ASC or doctors' office settings. These PROs, which have authority to deny Medicare claims reimbursement, are each required to promulgate their own separate guidelines for determining which medical procedures they consider appropriately or inappropriately to be performed in the inpatient setting.

AIOIS has carefully surveyed PROs and has determined that the guidelines on inpatient eye surgery for cataracts issued by many PROs are often non-existent or completely arbitrary, with the result being that elderly Medicare patients have often been seriously inconvenienced and sometimes imperiled. Without any published justification or any public hearings, some PROs have determined that cataract surgery -- performed on over half a million patients annually -- must not include an overnight (or longer) stay in the hospital for patients regardless of the patients' medical needs or personal conditions. PROs have mandated that cataract surgery be performed on an outpatient basis in hospitals or in ASCs if Medicare reimbursement is to be obtained.

Cataract surgery today, in fact, usually can be performed safely and effectively without a hospital stay. Advances in surgical techniques and the use of IOLs for post-surgical correction of vision have brought widespread improvement in cataract surgery results as well as an expansion of the population of potentially suitable patients. But there remain many medical and personal reasons why inpatient surgery is still best for some patients in some circumstances. An overnight or even several-day admission to the hospital is the preferred course of treatment for some patients. For example, patients with complicating conditions of the eye, with only one functioning eye, with coronary or other serious medical conditions, with a need for certain non-routine cataract surgery, with long distances to travel, or with inadequate care at home, might all have safer and more convenient cataract surgery if they were permitted by Medicare to spend one or a few nights in a hospital. Most cataract patients are elderly. Their average age is over seventy. Many are in their eighties and even nineties. In the past, the decision whether to be admitted to a hospital overnight or for a few days following cataract surgery was made by the surgeon and the patient together, taking into consideration all of the medical and practical circumstances. With the PRO program, in many areas this option is no longer available.

PROs have widely varying quotas or "targets" for reducing Medicare patient admissions (hospital stays) for cataract surgery. Thus, the PRO in Florida has arbitrarily agreed with the federal government to reduce admissions by 90 percent. Another PRO in New Mexico has agreed to a 15 percent reduction. No guidance in this area at all has been provided by Medicare authorities. In turn, not one PRO has exposed for public consideration the criteria they use to set their quotas.

"Horror stories" abound. One woman patient in her eighties was denied a night's stay in a hospital following her cataract surgery because the PRO said she had adequate care at home -- she lives with a husband, also in his eighties, who is a victim of Alzheimer's disease. Many PROs have refused requests for inpatient treatment despite medical histories of coronary problems. When a PRO recently refused to permit hospital admission for one eye surgeon's cataract patient during a blizzard in Maine, the surgeon took the patient to his own home to spend the night.

At a time when benefit reductions in the Medicare program are subject to extensive Congressional and public debate, one important Medicare benefit has already been eliminated -- the patient's option to stay in the hospital for cataract surgery if medical or personal conditions require it. The ecomonic ramifications are potentially important, of course, since cataract surgery is the most reimbursed surgical procedure under Medicare. But hospital admission for cataract surgery is likely necessary only in a minority of cases.

Thus, AIOIS believes that the Medicare authorities should require PROs to use sensible published guidelines to permit cataract and IOL surgery admission when it is best for the patient. AIOIS had petitioned Medicare for these guidelines, but that petition was denied. Recently, AIOIS filed a lawsuit here in Washington to compel guidelines that would permit cataract hospital admission in circumstances of medical or personal need. A copy of the AIOIS complaint is attached for the Committee's record.

Because the experience with PRO review has been so unsatisfactory due to the absence of guidelines speaking to the propriety of hospital admissions, AIOIS strongly believes that any outpatient review procedures considered by this Committee must be accompanied by workable, objective guidelines. With respect to admissions, such guidelines should identify the circumstances under which patients will be permitted to undergo surgery in the various particular settings. But more than that is needed with respect to outpatient and ASC review. Where PROs are allowed to review both inpatient and outpatient procedures, they will effectively be deciding not simply where the surgery will take place, but whether the surgery will be permitted to take place at all. Absent reasonable guidelines, arbitrary actions by PROs will go forever unchecked. Some patients will be denied medical care. Reasonable guidelines on the propriety of medical care are thus imperative.

Concerning such guidelines, AIOIS agrees with the position advanced by the Outpatient Opthalmic Surgery Society ("OOSS") before this Committee, that appropriate patient care criteria cannot establish binding visual acuity standards that do not take into account patients' individual needs and lifestyles. HCFA and the relevant professional societies and associations should work carefully together to develop reasonable patient care criteria to assist the PROs in their oversight functions. AIOIS stands willing to assist in that effort, with whatever expertise it can bring to bear on this issue of such importance to elderly Americans.

The Implant Society urges this Committee to mandate the development of adequate PRO guidelines, based upon a consensus of expertise of physicians and physician organizations and exposed to the "sunshine" of public scrutiny, before authorizing PRO review of outpatient surgery.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JUN 18 198

85-1928

AMERICAN INTRA-OCULAR
IMPLANT SOCIETY,
118 San Vincente Boulevard
Suite 208
Brentwood, CA 90049
(213) 395-3937

Plaintiff,

v.

Civil Action No. ____

MARGARET M. HECKLER,
Secretary
United States Department of
Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 245-7000

and

CAROLYNE K. DAVIS,
Administrator
Health Care Financing
Administration
United States Department of
Health and Human Services
700 East High Rise Building
6401 Security Boulevard
Baltimore, Maryland 21235
(301) 594-7914

Defendants.

COMPLAINT FOR INJUNCTIVE AND OTHER RELIEF

Plaintiff American Intra-Ocular Implant Society ("AIOIS"), by its attorneys, for its complaint against defendants Margaret M. Heckler and Carolyne K. Davis states:

ATTACHMENT

Nature of Action

1. AIOIS, a professional society of ophthalmologists, brings this action because Defendants, who are responsible for administering the federal Medicare health insurance program, have failed to observe the rulemaking procedures of the Peer Review Improvement Act of 1982 and the Administrative Procedure Act. Defendants have caused Peer Review Organizations ("PROs") to establish and utilize arbitrary and capricious quotas, criteria, and procedures, varying from state to state, which restrict admissions to hospitals when needed by patients undergoing cataract surgery covered by the Medicare program. AIOIS asks that Defendants be required to terminate use of these quotas, criteria, and procedures and to adopt substantive rules and regulations affecting hospital admission for cataract surgery only through public notice, comment, and hearing, as required by law.

Jurisdiction and Venue

2. The Court has jurisdiction of this action pursuant to 28 U.S.C. §§ 1331, 1361, 2201, and 2202.

3. Venue lies in this Court pursuant to 28 U.S.C. § 1391(e) and 5 U.S.C. § 703.

Parties

4. AIOIS is a national professional society of more than 4,000 ophthalmologists (physician eye surgeons) who perform cataract surgery. Cataract is a condition of the

eye in which the natural crystalline lens becomes clouded and impairs vision. Surgical removal of the lens is the only treatment for cataracts. Vision correction is then usually achieved through surgical implantation of an intraocular lens - a tiny plastic prostheses that replaces the natural lens. Cataract surgery is performed in both in-patient and out-patient settings, depending upon the medical and ocular needs of patients.

5. Defendant Margaret M. Heckler (the "Secretary"), named in her official capacity, is Secretary of the United States Department of Health and Human Services ("DHHS") and has statutory responsibility for administration of the Social Security Act, including the Medicare and PRO programs.

6. Defendant Carolyne K. Davis (the "Administrator"), named in her official capacity, is Administrator of the Health Care Financing Administration ("HCFA"), a division of DHHS, and has delegated responsibility for administering portions of the Social Security Act, including the Medicare and PRO programs.

Defendants' Unlawful Acts

7. The Peer Review Improvement Act of 1982 (Title I, Subtitle C of the Tax Equity and Fiscal Responsibility Act, Pub. L. 97-248, 42 U.S.C. § 1320c) authorized the Secretary, pursuant to the Act or "under regulations of the Secretary promulgated to carry out the provisions of the Act" (42

U.S.C. § 1320c(3)(a)(8)), to utilize Peer Review Organizations in administering the federal health insurance program for the elderly and disabled established by the Medicare Act, 42 U.S.C. § 1395 et seq. PROs review claims for Medicare reimbursement of medical services, including cataract surgery, to determine whether the services are reasonable and necessary and performed in the most appropriate setting. A PRO is a private organization, ordinarily composed of local medical practitioners, and ordinarily having purview over an entire state.

8. Defendants have, both by direction to PROs and by failure to direct PROs, permitted and encouraged arbitrary and capricious PRO quotas on hospital admissions for cataract surgery covered by the Medicare program, arbitrary and capricious PRO criteria for cataract surgery admissions, and arbitrary and capricious PRO procedures for review of planned or completed cataract surgery. As a result, PROs have adopted - without medical, practical or financial bases - irrational restrictions on in-patient cataract surgery. These restrictions constitute directly and indirectly the exercise of supervision and control over the practice of medicine and the manner in which medical services are provided, all in violation of the Medicare Act, 42 U.S.C. § 1395.

9. The restrictions on in-patient cataract surgery have been adopted and implemented by Defendants through PROs

without notice, comment, hearing, or other opportunity for public involvement as intended by Congress in the Peer Review Improvement Act and in the Administrative Procedure Act ("APA"), 5 U.S.C. § 553, and by DHHS in its own regulations, 36 Fed. Reg. 2532 (1971). Defendants have abdicated their statutory obligation to administer the Medicare and PRO programs by delegating uncircumscribed decision-making authority to privately-run PROs. Defendants have not directed through substantive rules and regulations how PROs should carry out their responsibilities with respect to in-patient cataract surgery. Defendants have not lawfully adopted substantive rules and regulations for evaluating the reasonableness of such activities of PROs. Defendants have not undertaken enforcement actions to terminate the arbitrary and capricious activities of PROs in restricting in-patient cataract surgery. In contrast, Defendants have promulgated rules and regulations concerning many other aspects of the PRO program that are no more substantive than the quotas, criteria, and procedures restricting in-patient cataract surgery.

10. Defendants' failure to direct PROs in carrying out their responsibilities with respect to in-patient cataract surgery, and the resulting arbitrary and capricious nature of PRO quotas, criteria, and procedures restricting that surgery, have caused irreparable injury to AIOIS and its members for which they have no adequate remedy at law.

11. On November 8, 1984, AIOIS filed a Petition for Institution of Rulemaking Procedures to Implement the Peer Review Improvement Act of 1982. A copy of the AIOIS Petition is attached as Exhibit A.

12. On May 2, 1985, the Administrator denied the AIOIS Petition. A copy of the Administrator's denial is attached as Exhibit B.

Prayer for Relief

WHEREFORE, AIOIS respectfully requests that:

1. The Court declare that Defendants' failure to institute rulemaking concerning PRO activities affecting in-patient cataract surgery violates the rights of AIOIS and its members under the Peer Review Improvement Act, the APA, and DHHS regulations, and is arbitrary and capricious, an abuse of discretion, and not otherwise in accordance with law.

2. The Court declare that the arbitrary and capricious quotas, criteria, and procedures restricting in-patient cataract surgery that have been established and utilized by PROs acting under Defendants' authority and control are null and void and constitute directly and indirectly the exercise of illegal supervision and control over the practice of medicine and the manner in which medical services are provided.

3. The Court declare that Defendants' denial of the AIOIS Petition for Institution of Rulemaking Procedures to

Implement the Peer Review Improvement Act of 1982 was arbitrary and capricious, an abuse of discretion, and not otherwise in accordance with law.

4. The Court enjoin Defendants, and PROs acting under Defendants' authority and control, from establishment or utilization of any quotas, criteria, or procedures restricting in-patient cataract surgery without public notice, comment, or hearing.

5. The Court compel, by issuance of a writ of mandamus, Defendants to promulgate forthwith any and all quotas, criteria, or procedures implementing the Peer Review Improvement Act in accordance with § 1320c-3(a)(8) of the Act, the APA, and Defendants' own regulations.

6. The Court enjoin establishment or utilization of any future quotas, criteria, or procedures restricting in-patient cataract surgery unless and until Defendants have issued substantive rules and regulations following public notice, comment, and hearing in accordance with the Peer Review Improvement Act, the APA, and Defendants' own regulations.

7. The Court award AIOIS its costs and reasonable attorney's fees.

8. The Court award such other and further relief as the Court may deem just and appropriate.

Respectfully submitted,

AMERICAN INTRA-OCULAR
IMPLANT SOCIETY

By:
Jerald A. Jacobs
One of its attorneys

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Dated: June 12, 1985

A

American Optometric Association

STATEMENT OF THE
AMERICAN OPTOMETRIC ASSOCIATION
before the
Senate Finance Committee
On Deficit Reduction

991-06

September 12, 1985

American Optometric Association
600 Maryland Avenue, S.W., Suite 400
Washington, D.C. 20024
(202) 484-9400

The American Optometric Association appreciates the opportunity to offer comments on the Committee's consideration of a deficit reduction plan. AOA is the national association representing 25,000 doctors of optometry.

AOA would specifically like to express strong support for Section 111 of the House Energy and Commerce Committee Medicare reconciliation package and urge the Finance Committee to include this provision in its package.

This provision would address a major inequity in the Medicare program by reimbursing presently covered eye/vision services under Medicare when provided by any practitioner licensed under state law to provide the services.

With the exception of post-cataract patients (those who have had the natural lens of the eye removed by surgery), Medicare beneficiaries who currently seek care from a doctor of optometry cannot be reimbursed by the program, even though the same services would be reimbursed if provided by any doctor of medicine or osteopathy, whether or not they specialize in diseases of the eye. Non-aphakic patients are faced with three equally undesirable choices: 1) personally pay for the services from limited incomes, 2) go without care altogether, or 3) switch from their chosen provider to an unknown one. Further, the last choice is not always feasible because of the lesser accessibility of ophthalmologists as compared with optometrists. Over a third of the nation's counties have optometrists in practice but no MD eye specialists.

It is important to note that amending Medicare in this way does not add any new services under the program. The services are already covered. What the bill would do is assure that all beneficiaries are treated equitably in obtaining these covered services. Attached to this statement is a table from a 1976 report by the Department of Health, Education and Welfare listing Medicare covered services which are within the scope of practice of and provided by both ophthalmologists and optometrists and their reimbursement status at that time (attachment 1). The only difference is that Medicare will reimburse patients, other than aphakic patients, who obtain the services from doctors of medicine or osteopathy but not those who obtain them from doctors of optometry.

The cost for correcting this inequity is minimal. The Congressional Budget Office estimates the provision contained in the House bill would cost the program $20 million in 1986; $155 million over three years. Further, if all Medicare beneficiaries had access to medical providers, as some have suggested, and were willing to change from optometrists, the total cost to the program would then exceed the costs of this proposal.

There is an additional factor we would like the committee to consider--the potential for doctors of optometry to reduce the number of unnecessary cataract extraction operations paid for by Medicare. The House Aging Committee has recently reported that between 23-36 percent of these operations paid for by Medicare are unnecessary, resulting in a yearly loss to the program of over a half billion dollars. Doctors of optometry are in an excellent position to help reduce this loss if their services are recognized equitably by the program. According to the Health Care Financing Administration (HCFA), 70 percent of new cataracts are diagnosed by optometrists. Logic would suggest that many of these patients will switch to medical providers because of the reimbursement bias, precluding any opportunity for the optometrist to act as a safequard against the premature or unnecessary surgeries reported by the House Aging Committee. We believe that the House Energy and Commerce provision on optometric services offers the opportunity to help correct this substantial problem by utilizing doctors of optometry as a "second opinion" before the fact. Doctors of optometry are trained, licensed and fully qualified to diagnose cataracts, determine the impact of the cataract on the patient's vision, and assess the necessity for surgery.

We would like to emphasize that patients in other federal programs are not faced with this problem. These programs either guarantee freedom-of-choice of practitioner or have no restrictions on the use of eye care providers. For example:

-- Under Medicaid, most eye examinations, including eye health exams, are provided by optometrists.

-- Most federally qualified HMO's utilize doctors of optometry, typically in a primary care role.

-- Federal employees and military dependents are guaranteed the ability to select optometrists for covered eye benefits. In fact, just last year Congress extended the vision care benefit under CHAMPUS without any distinction made between optometrists and physicians as providers.

Enactment of this provision would be a long overdue fulfillment of the freedom-of-choice policy under Medicare, set forth in its opening section as follows:

> "Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services."

It would also be consistent with a recent U.S. 5th Circuit Court of Appeals decision on the Title XIX Medical Assistance Program (Medicaid) in Louisiana, which ruled that optometrists who perform eye care services that are within the scope of optometric practice shall be reimbursed to the same extent and under the same standards as physician providers who perform thsoe same eye care services (Attachment 2).

This is clearly not a question of "turf," of what provider group is qualified to provide what services. That is a question that is properly left to the states, and the states answered it long ago by granting doctors of optometry the right to provide services now covered under Medicare. The language included in the House Energy and Commerce bill simply makes these services available to all beneficiaries on an equitable basis. This is truly a beneficiary bill, as evidenced by its endorsement by various groups such as the American Association of Retired Persons, the American Public Health Association, the National Association of Hispanic Elderly, the National Alliance of Senior Citizens, and the National Council on Aging.

In 1980, Congress recognized the professional qualifications of doctors of optometry when it made their services available to those Medicare patients who have had cataract surgery. We believe the time is long past due to treat all Medicare beneficiaries equally and we would urge the Committee to include this provision in its Medicare reconciliation package.

(3) services in connection with the provision of both temporary and permanent prosthetic lenses, including fitting and providing the lenses themselves. The only services for which optometrists may be reimbursed are dispensing services in connection with the actual fitting and provision of prosthetic lenses. Table I delineates the status of Part B reimbursement for services within the scope of practice of both physicians and optometrists.

TABLE I

Part B Reimbursement Status of Services to Cataract and Aphakic Patients which are Provided by both Physicians and Optometrists

Service*	Eligible for Part B Reimbursement Under Certain Conditions	
	MD/DO**	OD
Personal and Family Health History, Symptoms and Vision Requirements	X	
Visual acuity - distance and near, with and without correction	X	
External examination (eye and adjacent structures)	X	
Direct and indirect ophthalmoscopy	X	
Biomicroscopy	X	
Tonometry	X	
Central and peripheral visual fields	X	
Ophthalmometry/Keratometry	X	
Refraction - objective and subjective, distance and near		
Ocular motility and binocular function	X	
Visual perception, color vision, Stereopsis, motor	X	
Evaluation for contact lenses	X	
Evaluation for low vision aids	X	
Evaluation for vision training therapy	X	
Ophthalmic prosthesis and services	X	X

* Services listed include only those within the scope of practice of both physicians and optometrists. All of the listed services would not necessarily be provided by either provider to every cataract or aphakic patient during the course of each examination.

** Most of these services, when provided by physicians, are typically provided only by those specializing in Ophthalmology. However, any doctor of medicine or osteopathy is authorized to carry out any of the services listed and could be reimbursed for any covered services provided.

ATTACHMENT

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF FAMILY SECURITY
755 RIVERSIDE NORTH
P. O. BOX 44065 - PHONE - 504 342-5472
BATON ROUGE, LOUISIANA 70804

EDWIN W. EDWARDS
Governor

SANDRA L. ROBINSON, M.D.
Secretary
State Health Officer

February 11, 1985

TO: Optometrists Enrolled in the Title XIX Medical Assistance Program

RE: Optometric Services

Effective for services rendered October 29, 1984, and thereafter the Medical Assistance Program revised its program for eye care services coverage. Optometrists who perform eye care services that are within the scope of optometric practice will be reimbursed to the same extent and according to the same standards as physician providers who perform those same eye care services. This policy change was implemented in accordance with the judgment of the U. S. Court of Appeals, 5th Circuit, in the case of Sandefur vs Cherry, rendered on October 29, 1984.

The program policy regarding service limits, exclusions, and reimbursement methodology that applies to physicians participating in the program will likewise apply to optometrist providers. The necessary program and claim processing changes have been completed, and optometrists can begin billing immediately for covered services performed on or after October 29, 1984.

Optometrists are to bill on the HCFA 1500 professional services claim form using CPT-4 procedure codes and ICD-9-CM diagnosis codes.

The Louisiana State Board of Optometry Examiners has certified the following CPT-4 codes to be within the scope of Optometric practice in Louisiana. Therefore, in accordance with the court order, the following CPT-4 codes are approved for program coverage when rendered by optometrists:

90000
90010
90015
90017
90020
90030
90040
90050
90060
90070
90080
90600
90605
90610
90620
90630
90640
90641
90642
90643
92002
92004
92012
92014
92020
92060
92065
92081
92082
92083
92100
92140
92225
92226
92250
92260
92275
92280
92283
92284
92285

Descriptions of the above codes and explanations for appropriate use in billing can be found in the CPT-4 Procedure Code Book.

Optometrists are to discontinue billing state assigned procedure codes 00014 and 00015 effective February 15, 1985.

Provider reimbursement for eye care services provided by optometrists and physicians are subject to the requirements and limits listed below:

1. Examination and/or treatment of an eye condition other than refractive error.

2. Refractions following cataract surgery.

   NOTE: This service is available to all eligible recipients.

3. Routine eye examinations for EPSDT eligible recipients under age 21.

   NOTE: Routine eye exams are allowed only for EPSDT eligible recipients under age 21.

4. Regular eyeglasses or contact lenses for EPSDT eligible recipients under age 21.

5. Cataract glasses or contact lenses following cataract surgery are limited to one permanent pair with the exception of EPSDT eligible recipients under age 21.

The PROFESSIONAL SERVICES provider manual is being revised to reflect the above program changes. Providers will be sent these revisions under separate cover by SDC, the fiscal intermediary.

If you have any questions regarding this change, please contact the Physician Program at (504) 342-6472.

Sincerely,

Marjorie T. S

Marjorie T. Stewart
Assistant Secretary

A

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Recommendations for the Medicare Program

Presented to the
Committee on Finance
U.S. Senate

September 6, 1985

aamc

Association of American Medical Colleges / One Dupont Circle, N.W. / Washington, D.C. 20036 / (202) 828-0490

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to comment on the current policy debate for Medicare's prospective payment system. The Association's Council of Teaching Hospitals (COTH) includes over 350 major teaching hospitals participating in the Medicare program. In 1982, the most recent year on which the Association has data, COTH hospitals cared for over 1,680,000 Medicare admissions. Thus, the Medicare prospective payment system has a major impact on our members.

Prospective Payment: Explaining Differences

Under prospective payments, hospitals receive up to six different types of payments for inpatient services:

- Cost Reimbursement Payments

  Direct Medical Education Costs
  Capital Costs (through 1986)
  Distinct Part Units

- Prospectively Determined Payments

  Per Discharge DRG Payments
  Outlier Payments
  Resident-to-Bed Adjustment Payments (in teaching hospitals)

For the prospectively-determined payments, it is crucial to recognize that the basic unit of payment is the individual patient. The actual payment is determined by adjusting an average price by an index of expected case costliness (i.e., the DRG weight). The average price for a hospital is based on its own hospital-specific costs, the average costs of hospitals in its region, and the average costs of hospitals nationally. During the transition period, hospitals began with a per case price based 75% on their own costs. By the fourth year, hospitals receive a price per case based 100% on the national average. The national average for a particular hospital is adjusted by an area wage index to recognize differences in the cost of employee salaries.

Transition Schedule

It must be understood that by year four only three differences across hospitals are recognized in the basic per case payments: rural-urban location, local area salaries as measured by the wage index and the type of patient as measured by the DRG categories. All other differences in hospital costs are ignored by year four. The differences ignored in prospective payment include hospital bed size, range of services offered, socioeconomic mix of patients, central city or suburban location, and input price differences other than wages. Past research has shown each of these variables account for real differences in hospital costs. Ignoring these variables caused relatively minor problems when prices were based 75% on the hospital-specific price components because the hospital's historical costs reflected all of its differences from the "average" hospital. As the transition moves forward, however, the hospital-specific price component decreases and the price paid does not recognize major differences in the costs of different hospitals.

Therefore, the AAMC believes too few variables are being used in setting the price per case for hospitals. As the hospital-specific price component disappears, the present system lacks adequate adjustments that would recognize legitimate differences in the costs of different hospitals. This lack of adequate adjustments could be substantially ameliorated if the price per case retained a significant component of the hospital-specific costs. Therefore, THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS TEMPORARILY HALTING THE PHASE-IN AT 50% HOSPITAL-SPECIFIC AND 50% FEDERAL COMPONENTS TO ALLOW TIME FOR HOSPITALS, THEIR ASSOCIATIONS, HCFA, AND CONGRESSIONAL COMMITTEES TO ANALYZE THE IMPACT OF HAVING A PROSPECTIVE PAYMENT SYSTEM BASED ON NATIONAL AVERAGE PRICES.

Direct Medical Education Costs

To provide clinical training for residents, nurses, and allied health personnel, hospitals incur costs beyond those necessary for patient care. Since its inception, Medicare has paid its share of these added direct expenses on a cost reimbursement basis. Under prospective payment, cost reimbursement for these expenses is continued using the "direct medical education passthrough."

The justification for this passthrough was clearly described in the Secretary's 1982 report Hospital Prospective Payment for Medicare (pp 47-48):

> The Department believes that the direct costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital.

Congress supported the Department's position that it was not appropriate to include clinical training costs in the DRG payment and approved continuing to pay the costs of graduate medical education on a cost reimbursement basis separate from the DRG based per case payment.

Medicare's share of the direct medical education passthrough is determined using generally accepted accounting principles and Medicare reimbursement regulations. The hospital accounting system accumulates expenses directly associated with these activities in specific cost centers. For example, hospital expenses for resident stipends are recorded in the graduate medical education (or intern and resident) cost center. After all expenses are entered, overhead expenses -- such as administration, maintenance, and utilities -- are allocated (or apportioned) across the Medicare recognized cost centers such as graduate medical education. Thus, the cost being reimbursed through the direct medical education payment includes only Medicare's share of expenses incurred by the cost center and allocated overhead.

Reducing Medicare's share of the costs of medical education in the hospital will weaken graduate medical, nursing, and allied health education programs. It will also set a precedent which other payers may cite as the basis for reducing their support. Rather than having deficit reduction politics determine future health manpower policy, the AAMC believes that public policy on financing graduate medical education should be fully debated and resolved prior to altering the current passthrough. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS CONTINUING THE PASSTHROUGH FOR DIRECT MEDICAL EDUCATION COSTS UNTIL A COMPREHENSIVE ASSESSMENT OF FINANCING GRADUATE MEDICAL EDUCATION IS COMPLETED AND FULLY CONSIDERED.

The AAMC is fully aware of the Federal budget deficit and its impacts on our economy. At the same time, it should be noted that teaching hospitals have experienced major Medicare payment reductions in the past few years. Hospitals have responded by holding down costs and cutting expenses, including personnel. Nevertheless, hospitals still face the inflation present in our general economy including inflation in the cost of operating clinical training programs. Any freeze weakens the hospital's financial stability. Therefore, if Congress must alter the direct medical education passthrough, THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS THAT THE MEDICARE PASSTHROUGH FOR DIRECT MEDICAL EDUCATION COSTS BE INCREASED BY THE SAME PERCENTAGE USED TO INCREASE THE FEDERAL COMPONENT OF THE DRG PRICES.

United States medical and osteopathic schools are presently graduating over 16,000 physicians annually. All recent physician manpower studies show U.S. medical and osteopathic schools are training an adequate number of physicians for our nation. In addition to U.S. graduates, a large number of foreign-trained physicians are entering the United States. Many of these foreign trained physicians enter residency training programs where they are supported by patient service revenues, including Medicare payments. The AAMC believes our society has a responsibility to provide necessary clinical training for physicians from U.S. schools. The Association believes no similar obligation exist for graduates of non-accredited schools or schools from outside the United States. Therefore,

THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS ELIMINATING MEDICARE SUPPORT FOR ALL RESIDENTS WHO ARE NOT GRADUATES OF ACCREDITED MEDICAL (OR OSTEOPATHIC) SCHOOLS LOCATED IN THE U.S. OR CANADA.

It should be understood that for some hospitals, where residents provide a large proportion of patient services, the immediate elimination of Medicare support for FMGs would cause substantial access and service problems for Medicare beneficiaries. The AAMC does not wish to decrease patient access to service. Therefore,

THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS PROVIDING A THREE YEAR PHASE-OUT FOR MEDICARE SUPPORT OF RESIDENTS GRADUATING FROM FOREIGN MEDICAL SCHOOLS.

A three year transition should allow the hospital and its medical staff to modify programs, personnel, and services while maintaining patient access to care. The Association recognizes that our nation may wish to continue training a limited number of foreign graduates for purposes of economic development, foreign relations, cultural exchange, and foreign aid. The AAMC supports public funding for foreign physicians in programs designed to train and return them to their own society; however, the AAMC believes special purpose funds should be used for these training purposes.

Education for the contemporary practice of medicine includes both undergraduate medical education in a medical school and graduate medical education in a teaching hospital or other clinical site. Medicine involves a number of different specialties, and each specialty area has developed its own residency training period. The AAMC believes each of those training programs is essential and in the national interest; however, in the present fiscal situation, the AAMC understands program policies and fiscal policies must be balanced. The AAMC believes that any limitation on Medicare support for graduate medical education should not be arbitrary or inconsistent with adequate minimal residency training. Because the initial skills and techniques needed by different specialties require different lengths of training,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES BELIEVES SUPPORT THROUGH AT LEAST INITIAL BOARD ELIGIBILITY (TO A FIVE YEAR MAXIMUM) IS AN ESSENTIAL MINIMUM TRAINING PERIOD THAT EVERY PATIENT SERVICE PAYER SHOULD HELP FINANCE.

It should be understood that this approach might not provide full support for the subspecialty fields of internal medicine, some surgical subspecialties, and few other subspecialties. The AAMC does not want to leave the impression that these programs are either unnecessary or conducted without training costs.

Therefore, the AAMC requests that any legislation limiting Medicare's financing role to initial board eligibility include in its accompanying Committee report a clear statement that it is an appropriate function for other Federal agencies and programs -- such as the Public Health Service, the Veterans Administration, and the Department of Defense, as well as other public and private sources -- to support subspecialty training beyond primary board eligibility.

Under the present statute, a resident is defined as a hospital cost when providing services in the context of an approved training program. The resident under these circumstances is not allowed to bill on a Part B basis for any personal medical services provided. The AAMC assumes this arrangement will be retained for residents included in the passthrough. For residents who are not eligible for Part A Medicare funding, a reduction in Medicare support raises a number of difficult policy questions. For example, under present law, residents in thoracic surgery and cardiology programs may not bill Medicare patients for services on a Part B which the physician-in-training is fully qualified to provide.

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS ALLOWING PART B BILLS TO BE RENDERED FOR PHYSICIAN SERVICES PROVIDED BY INDIVIDUALS IN RESIDENCY YEARS WHICH MAY NOT BE INCLUDED IN A HOSPITAL'S COSTS BUT ONLY FOR THOSE SERVICES FOR WHICH THE RESIDENT HAS COMPLETED A RESIDENCY TRAINING PROGRAM.

The Indirect Medical Education Adjustment

When prospective payment was being considered, the Congressional Budget Office compared the system's impact on teaching and non-teaching hospitals. 71% of teaching hospitals would lose money compared with TEFRA, while only 32% of non-teaching hospitals would lose money. It should be noted that this impact assessment assumed the original or single resident-to-bed adjustment. Four factors contributed heavily to this adverse impact:

- First, when HCFA set the regional and national average prices, they computed the average on a hospital-weighted, rather than a case weighted, basis. Therefore, in computing the average, a major teaching hospital admitting 10,000 Medicare cases had the same impact as a small suburban hospital with 750 Medicare admissions. The effect of the use of a hospital-weighted average is that the "price norm" (i.e., average price) for urban hospitals is a 255 bed hospital. In the Council of Teaching Hospitals, the average hospital has 562 beds. The scope of services and therefore average costs of a hospital generally vary with bed size. This was recognized in the TEFRA limits where hospitals were compared using bed size groups. HCFA's use of an approach that sets prices approximating the costs of a 255 bed hospital hurt teaching hospitals.

- Secondly, the DRGs have only 468 categories for recognizing differences between patients. If each hospital received an equal variety of patients in each DRG, 468 categories would not cause serious problems. Teaching hospitals do not receive a random mix of patients. Teaching hospitals receive the sickest, most difficult and most costly cases. Without such an adjustment, teaching hospitals are hurt by an average pricing system. Unfortunately, no easily implemented system to adjust the DRG for the difference in severity was available in 1983 and none is yet available.

- Third, hospitals in large metropolitan areas have higher average costs than those in smaller cities, and central city hospitals have higher average costs than suburban hospitals. These costs include differences such as increased security and social services departments. Teaching hospitals are heavily concentrated in the central cities of major metropolitan areas. Because the prospective payment system does not adjust for the higher costs of central cities, teaching hospitals are hurt by the average pricing system of prospective payment.

- Finally, when HCFA estimated the factor for the resident-to-bed adjustment, they included two variables in the analysis -- hospital bed size and urban area size -- which were not included in the payment system. As a result, the computed adjustment was understated and teaching hospitals were adversely impacted until Congress doubled the computed adjustment.

Thus, while the resident-to-bed adjustment is called the "indirect adjustment for cost accompanying medical education," it is, in fact, a proxy measure to provide appropriate compensation for the added patient service costs borne by teaching hospitals. Thus it helps correct for the fact that too few variables are used to set prices in the current system. Nevertheless, its "medical education" label permits the adjustment to be viewed as an educational payment rather than a correction for statistically consistent differences in cost between teaching and non-teaching hospitals. The AAMC is concerned about this misperception.

The resident-to-bed adjustment is a crucial equity factor in prospective payment. It should be retained, but it should be properly estimated. An unbiased and more defensible adjustment can be obtained if the adjustment is re-estimated with an equation based only on the factors used in determining DRG prices. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORTS RECOMPUTING THE RESIDENT-TO-BED ADJUSTMENT USING A REGRESSION EQUATION WHICH INCORPORATES ONLY VARIABLES USED IN DETERMINING HOSPITAL DRG PAYMENTS.

In developing the resident-to-bed adjustment, HCFA used residents assigned to the hospital's inpatient and outpatient services. Having established the size of the adjustment using residents in both inpatient and outpatient settings, it would be inappropriate to distribute the adjustment to hospitals using only residents in inpatient settings. The inappropriateness of using only inpatient residents to distribute an adjustment calculated using both inpatient and outpatient residents was recognized by HCFA in the regulations for the first prospective payment year on page 39778 of the September 1, 1983 Federal Register.

> However, due to the way in which the adjustment factor was originally computed, interns and residents working in outpatient areas and emergency rooms should be included in the calculation of the ratio. In the original computation of the adjustment factor, interns and residents working in these areas were included in the analysis, even though the costs were excluded. Further, these areas would not affect the bed count assigned to the facility. Therefore, if we were to exclude these interns and residents in applying the factor, the amount of the adjustment would be incorrect because we would be altering only one element of the variable and failing to maintain comparability between the methodology

> used for developing the adjustment factor and subsequently standardizing hospital costs based on that factor.

In the September 3, 1985 regulations for prospective payment, HCFA violated this policy by changing the rules for the distribution of the resident-to-bed adjustment to exclude residents caring for outpatients from the count. The AAMC believes HCFA's original position is correct -- as long as residents of all types are included in computing the adjustment, they should all be included in paying out the adjustment. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES STRONGLY RECOMMENDS REQUIRING THE SECRETARY TO CONTINUE INCLUDING RESIDENTS ASSIGNED TO OUTPATIENT SETTINGS IN THE ADJUSTMENT UNTIL THE PERCENTAGE ADJUSTMENT ITSELF IS DETERMINED USING ONLY RESIDENTS ASSIGNED TO INPATIENT SETTINGS.

Similarly, if some residents originally included in computing the resident-to-bed computation are excluded from a revised direct cost passthrough, the excluded residents should continue to be included in the resident-to-bed adjustment. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES STRONGLY RECOMMENDS REQUIRING THE SECRETARY TO CONTINUE INCLUDING RESIDENTS FROM ALL TRAINING PROGRAMS IN THE ADJUSTMENT EVEN IF THE RESIDENTS ARE NOT INCLUDED IN THE MEDICAL EDUCATION PASSTHROUGH.

DRG Payment Rates

The prospective payment system was enacted to encourage hospitals to reduce costs. Every available piece of evidence indicates hospitals are responding by reducing their costs. Moreover, and contrary to those who felt the system would be manipulated, hospitals have also experienced a drop in admissions. Clearly, hospitals have responded to the national mandate. Therefore, in an economy that is still experiencing significant inflation and with a Medicare population that includes growing numbers of the very old and the frail elderly, the AAMC believes it is inappropriate to impose a price freeze and ignore the increased costs hospitals must incur for the personnel, goods, and services they buy. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS INCREASING THE HOSPITAL-SPECIFIC AND FEDERAL COMPONENTS OF DRG PRICES AS RECOMMENDED BY THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Disproportionate Share Providers

Hospitals serving a disproportionate share of the poor face significant problems. Within a DRG, low income patients tend to use more services than non-indigent patients. This often results from waiting longer to seek medical care, or because of chronic illnesses and complicating conditions, or from the absence of a suitable home environment to which the patient can be discharged. Thus, indigent Medicare patients tend to be more costly than non-indigent Medicare patients. These cost should be recognized in the prospective payment system.

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS THAT THE HIGHER COSTS OF INDIGENT MEDICARE PATIENTS IS AN APPROPRIATE EXPENSE FOR THE MEDICARE TRUST FUND.

Two major approaches have generally been used in efforts to identify disproportionate share providers. The first compares revenue ratios. For example, the ratio of bad debt and charity care charges to total charges might be used to categorize hospitals. The second approach, compares patient volumes, in days or admissions, across hospitals. For example the proportion of Medicaid patient days to total days might be used to categorize hospitals. While either approach can be used,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES PREFERS USING THE PATIENT VOLUME APPROACH OVER THE REVENUE APPROACH TO IDENTIFY DISPROPORTIONATE SHARE HOSPITALS.

There are at least three approaches to establishing the amount of the payment for a qualifying disproportionate share provider. First, an exception process could be employed in which the qualifying hospital identifies its atypical costs. Past experience with the exceptions process for Section 223 limits demonstrates the weaknesses of an exceptions approach. A second payment approach would use cost reimbursement to pay those specific expenses which are more prevalent in disproportionate share hospitals. For example, a cost reimbursement passthrough could be established for personnel working in security, social work, and translator services. A third approach uses an observed statistical relationship between the variable used to define disproportionate share hospitals and observed variation in hospital costs. For example, the ratio of a hospital's indigent Medicaid patients could be related to a percentage increase in its payments.

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES PREFERS THAT THE DISPROPORTIONATE SHARE ADJUSTMENT BE COMPUTED USING A REGRESSION EQUATION THAT INCLUDES ONLY VARIABLES USED TO DETERMINE DRG PAYMENT.

Wage Index Adjustments

The wage index numbers used since the beginning of prospective payment are based on incorrect data. The 1984 Tax Reform Act requires HCFA to obtain correct data, recompute the index numbers, and retroactively adjust PPS payments back to October 1, 1983. For hospitals with an increasing index this is not a problem. For hospitals with a declining index, the hospital will have to simultaneously adjust to a lower payment rate and return the past overpayment. This could create major financial problems and threaten hospital viability. Moreover, the retroactive adjustment suggests that corrections in PPS data should be applied back to the start of the program. This is inconsistent with the prospective nature of the system. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORTS CORRECTING THE WAGE INDEX NUMBERS USED IN PROSPECTIVE PAYMENTS BUT RECOMMENDS AMENDING THE LAW TO ELIMINATE THE CURRENT REQUIREMENT THAT THE NEW INDEX NUMBERS BE APPLIED RETROACTIVELY TO OCTOBER 1, 1983.

Physician Fee Payments

Physician fees for services provided to Medicare beneficiaries have been frozen for fifteen months. No recognition has been provided for the increasing costs of practice, particularly the rapidly increasing premiums for malpractice insurance. In addition, a significant percentage of practicing physicians became "participating physicians" in an argument which promised to recognize their increased charges when the freeze expired on October 1, 1986.

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES IS OPPOSED TO AN EXTENSION OF THE PHYSICIAN FEE FREEZE AND URGES FEE INCREASES FOR BOTH PARTICIPATING AND NON-PARTICIPATING PHYSICIANS.

Conclusion

If the Medicare prospective payment system is to provide hospitals and physicians with an appropriate incentive for efficiency, methodological weaknesses must be eliminated, inaccurate data must be corrected, and real differences in the costs should be recognized. The AAMC recommendations have been developed to provide a more reasonable and equitable prospective payment system.

CHAMBER OF COMMERCE
OF THE
UNITED STATES OF AMERICA

ALBERT D. BOURLAND
VICE PRESIDENT
CONGRESSIONAL RELATIONS

1615 H STREET, N.W.
WASHINGTON, D.C. 20062
202/463-5600

September 12, 1985

The Honorable Bob Packwood
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Chairman Packwood:

On behalf of the U.S. Chamber of Commerce, I respectfully urge the Senate Finance Committee to reject proposals mandating which individuals or types of health care services must be covered under private employee group health benefit plans, in connection with action on the federal budget deficit. Such mandates are not assumed in the budget resolution and would have no effect on the deficit but would have a major effect on employers and employees.

In brief, the U.S. Chamber supports the present system of voluntary, nondiscriminatory, private-sector employee health care plans which can vary in accordance with the needs and financial resources of employers and employees. Federal requirements mandating plan design or financing would limit flexibility and raise costs, just as voluntary business efforts to institute broad cost management reforms are beginning to produce results.

In addition, mandates governing private employee group health benefits plans would be a major reversal of federal employee benefits policy. However, no announcement has been made that such a policy change is under consideration, and little attention has been given to the possible consequences. Fairness to the affected parties demands that there first be an opportunity for a thorough policy debate similar to the discussions of retirement policy preceding enactment of the Federal Employee Retirement Income Security Act (ERISA).

Experience with existing federal health programs has shown them to be costly, bureaucratic, and difficult to revise in response to changing health care needs. Extending the rigidity of statutory mandates to private employee group health plans will substitute political pressure for sound economic judgment and thereby undermine the basis for their success. Ultimately, mandated benefits will force workers to choose between lower wages or loss of benefits they prefer.

The Chamber would be happy to work with the members of the Committee on Finance to address these concerns. For more information, please feel free to have your staff contact Eric J. Oxfeld, our Manager of Health Care and Employee Benefits, at 463-5514.

I request that you include our views in the hearings record on deficit reduction.

Sincerely,

Albert Bourland

Albert D. Bourland

cc: Members of Committee, Staff Counsels

CITY OF ZEELAND
21 South Elm Street • Zeeland, Michigan 49464

"City of Creative
Craftsmanship"

September 9, 1985

Senate Finance Committee
Room 219
Senate Dirksen Office Building
Washington, D.C. 20510

HOUSE BILL HR 3128

The City of Zeeland is concerned about pending legislation which would would make joining the Social Security/Medicare program mandatory for state and local governments.

The city has considered carefully the impact of such legislation on the budget process and ultimately its citizens. A position paper has been prepared identifying the issues. The paper is presented to the Senate Finance Committee for consideration during the hearings scheduled for September 11-13.

I encourage the committee not to support legislation which would mandate participation by local units of government. If such legislation is to be passed, you are encouranged to consider a plan which would phase in such coverage and allow units of government to plan and budget the additional cost.

Thank you for your consideration of this information

Donald G. Disselkoen, Mayor

mr
cc Hon. Donald W. Riegle, Jr.
Hon. Carl Levin
Hon. Mark Siljander
Hon. Guy Vander Jagt

IMPLICATIONS OF COMPULSORY COVERAGE OF CITY EMPLOYEES UNDER MEDICARE AND SOCIAL SECURITY

Position Taken By: City of Zeeland, Michigan

Prepared By: Donald Komejan, Personnel Director

Date Prepared: September 6, 1985

This is a statement of position regarding the effects of legislation under consideration by the Senate to mandate (1) Medicare premiums for all employees not currently taxed for them and (2) full Social Security taxes (including Medicare) for all city employees hired after December 31, 1985.

If these considerations are adopted as legislation, it will mark the first time that joining the Social Security/Medicare program will become mandatory for state and local governments. Hearings are scheduled with members of the Senate Finance Committee on September 11-13 regarding mandatory Medicare coverage of city employees, as proposed by the HR 3128 and as also considered within a two-pronged proposal of the Senate.

Fiscal Implications

For the City of Zeeland, the fiscal implications are those of increased operating costs for payroll based taxes as well as potential increased costs for modifications to computerized payroll software applications.

The impact from mandated Medicare coverage after December 31, 1985 is projected at $2,000 per year at the current payroll contribution rates. If both Medicare and Social Security coverage are mandated, the incremental payroll cost is projected at $10,000 per year at the current payroll contribution rates.

These projections take into consideration the current plan and agreement which extends Social Security coverage to full-time employees of the City of Zeeland. The projected incremental costs would be incurred for extention of such coverage to the part-time employees.

Additionally, potential computer program modification costs to accomodate mandated Medicare coverage are projected at $1,000.

If Social Security coverage were to be compulsory for all of the City of Zeeland's employees, the incremental costs represent an increase to the General Operating Fund of approximately 1%.

Financial Planning and Budgeting Implications

It is of utmost importance that any proposal for compulsory Social Security coverage provide a means to phase in such coverage. This is necessary to permit local governments the lead time needed to include the incremental operating costs into the financial planning and budgeting process. The implementation date for compulsory coverage should be no sooner that one year from passage of such legislation, with an eighteen month period prior to implementation even more advisable.

Without the provision of an adequate implementation timetable, the additional costs of mandatory Social Security coverage will have to be incurred by local units of government within budgeting plans that have not provided for such costs. The financial burden resulting from poor fiscal planning and the lack of an adequate implementation timetable for mandated coverage should not be imposed on local governmental units who must operate within balanced budget constraints.

It is therefore critical to local governments that any compulsory coverage legislation provide an adequate phase-in period prior to its effective date.

HFMA

HEALTHCARE
FINANCIAL
MANAGEMENT
ASSOCIATION

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STATEMENT OF THE HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION TO THE UNITED STATES SENATE COMMITTEE ON FINANCE ON ISSUES RELATED TO THE MEDICARE PROSPECTIVE PRICE SETTING (PPS) SYSTEM

September 27, 1985
(hearing held September 13, 1985)

Summary

- o PPS rates should not be frozen
- o To permit time to correct inequities, a delay in transition to national rates is appropriate
- o We support use of the new wage index effective on the date that a decision about the index is made.
- o An HFMA task force is addressing the special problems of disproportionate share.
- o An HFMA task force supported "retention of existing return on equity provisions for investor-owned hospitals." (We also urge that tax-exempt financing be retained.)
- o A change in the indirect medical education allowance in the absence of specific recognition of differences in case complexity would be premature.
- o There is little alternative but to continue to fund medical education through established means.

About HFMA

The Healthcare Financial Management Association (HFMA) is a professional membership association composed of over 25,000 individuals in 74 chapters who are financial managers of hospitals and other healthcare institutions or who are closely associated with the financial management activities of healthcare providers. HFMA adopted "General Guidance Concerning Prospectively Determined Prices" on May 28,

1982. These comments are based upon that guidance and subsequent task force reports and resolutions of our organization.

Rate Freeze

The Administration has inappropriately imposed a freeze on hospital payment rates. Significant reduction in Medicare spending has been achieved since the inauguration of PPS. Thus, the incentives established by this new system are achieving federal budget objectives. In letters to Congress in January, March and earlier in September, we urged that PPS rates not be frozen. We recognize the overall budget problem of the federal government and have previously offered a variety of actions that might be taken to reduce federal spending for Medicare while still preserving the incentives inherent in PPS. We continue to believe that a freeze on rates sends all the wrong signals to the industry and undermines the cooperative efforts that have characterized implementation of PPS to date.

Transition toward national DRG rates

There are a number of deficiencies in the present PPS methodology, some of which are being addressed by this hearing. Some of the current deficiencies include:

- the delay in use of a relevant wage index;
- the failure to recognize severity of illness;
- the lack of knowledge about practice pattern differences;
- the failure to consider such influences on resource consumption, other than wage rates, as location (urban/rural, core/ring, hot/cold) or age and configuration of plant;
- the exclusion of provisions for patients to participate financially in their service decisons;
- the effect of serving a large proportion of Medicare, Medicaid and indigent patients;
- the unresolved issues from the base year; and
- the lack of appeal rights.

These deficiencies in the system result in the greatest inequity when rates are based on national averages. Studies of these issues and corrective actions have been slow. HFMA urges studies and actions that will contribute to the proper evolution of PPS and improve equity of the system. Further transition toward national rates will exacerbate the inequities resulting from the current deficiencies. A delay in transition should have no effect on total Medicare spending. Accordingly, a delay in transition to national rates is appropriate.

Wage index

The wage index initially used in PPS rates is undesirable for a number of reasons. A recently completed wage survey that HFMA actively supported, corrects for some of the initial deficiencies. The index as now calculated is still far from ideal, but is an improvement. HFMA believes that decisions about PPS rates should be made on a prospective basis. Therefore, HFMA supports the prospective application of a new wage index. It is probably most administratively feasible to make the new index applicable October 1, 1985. Since the current index contains inequities, we support use of the new wage index as promptly as administratively feasible. Even though the current index contains inequities, we believe the long-range implications of retroactive application of any change in the PPS system outweighs the desirability of correcting these past deficiencies.

Disproportionate share

An HFMA task force is currently studying many aspects of uncompensated services, including the problems associated with treating a disproportionate share of low-income patients. HFMA has consistently, since the establishment of Medicare, felt that rules denying any Medicare participation in the provision of uncompensated services to be inappropriate. This inequity is most severe for the disproportionate-share hospital, but should be corrected for all hospitals. Our task force is addressing the special problems of disproportionate share. A draft report has been released for comment, but does not yet represent a position of HFMA.

Return on equity

An HFMA task force has studied the issue of Medicare payment for capital-related costs in connection with PPS. The task force concluded that, "a return on equity after taxes is essential to hospitals of all ownership types," but recognized that "federal Medicare spending objectives do not permit adding return on equity into prices paid to tax-exempt hospitals at this time." Accordingly, the task force supported "retention of existing return on equity provisions for investor-owned hospitals." The task force recognized that return on equity is only one of a variety of differences between tax-exempt and investor-owned hospitals, such as access to investment capital, philanthropy and the extent of use of tax-exempt financing. HFMA feels that access to capital is absolutely essential and takes this occasion to urge that tax-exempt financing be retained.

Case complexity

There is inadequate data available to measure and evaluate case complexity. HFMA has supported a proposed HCFA study of case coding which would identify that portion of case-mix change that is attributable to changes in coding methodology. We recently wrote to members of this committee urging their action to obtain this needed information. It is generally acknowledged that the indirect medical education allowance was intented to be a crude proxy for differences in case complexity. We support a more direct recognition of and payment for differences in case complexity, and believe a change in the indirect medical education allowance, in the absence of specific recognition of differences in case complexity, would be premature. Furthermore, PPS rates for all providers were decreased in order to provide funds to make indirect medical education payments. From the standpoint of equity, if indirect medical education payments are reduced, the funds thus saved should be restored to the average payment rates for all PPS participating providers.

Medical education

The cost of medical eduction must be paid for or the availability of these essential skills and their benefit to society will be diminished. Since medical education is currently being paid for on the basis of actual costs incurred by those institutions providing the services, a freeze in payments will require an immediate curtailment of expenditures at least to offset the effect of inflation. Depending upon the way in which a freeze is implemented, organizations may have to decide whether education can be continued at all. A freeze in rates will also effectively preclude any new institutions from becoming involved with medical education. Other means for paying for medical education may be consistent with sound public policy objectives, but until appropriate means for paying for medical education are devised and implemented, there is little alternative but to continue to fund this essential activity through established means. Also, the indirect medical education allowance compensates not only for case complexity, but also for essential attributes of education. Thus, it is essential to continue the indirect medical education payment to institutions engaged in direct medical education activities.

More information

If you or your staff have questions on any of the views expressed above or would like to have copies of any of the studies or position statements referenced, please feel free to contact Ted Giovanis or Ronald Kovener in HFMA's Washington office. Thank you for the opportunity to present comments on behalf of our members.

9/27/85

Sept 11th

INTERNATIONAL ASSOCIATION OF AIRPORT DUTY FREE STORES

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RECORD COPY

STATEMENT
of the
INTERNATIONAL ASSOCIATION OF AIRPORT DUTY FREE STORES
Committee on Finance
U.S. Senate
Concerning
U.S. Customs Service Users Fees Contained
in
Deficit Reduction Plans

September 11, 1985
Washington, DC

By: David Bernstein
President

This statement is submitted on behalf of the International Association of Airport Duty Free Stores (IAADFS) incident to consideration by the U.S. Senate Finance Committee of the authorization of User Fees for U. S. Customs Services as a means to reduce the federal deficit.

The IAADFS is a trade association which represents Operators of airport duty free shops in the Western Hemisphere and Suppliers of duty free products. Included in the membership are fourteen companies who operate duty free stores at most U.S. airports which have scheduled international flights as well as suppliers of products such as liquor and tobacco items.

Airport authorities receive millions of dollars annually from the concession fees paid by U.S. operators of airport duty free stores. These fees represent a significant portion of airport revenues (approximately 43% in the case of Honolulu) and, at some airports, are in excess of $20 million annually.

The "User Fee" proposal should not apply to Airport Duty Free Store operations for the following reasons:

o Full reimbursement is already made by Airport Shop operators for services provided by the U.S. Customs Service. This reimbursement is in the form of payment of actual personnel costs plus benefits as well as by licensing, inspection, and administrative fees.

o The assessement of "User Fees" would result in significant increased costs which could cause the closing of a number of aiport duty free operations with an accompanying loss of concession fees to Airport Authorities,

o "User Fees" would significantly increase the cost of merchandise carried in a duty free shop. This would make airport duty free shopping less competitive and attractive to both the U.S. and international traveler with a corresponding loss in merchandise sales.

o Since Customs is already reimbursed for services provided airport duty free shop operators, the assessment of additional fees is considered a violation of the General Agreement on Tariffs and Trade (GATT), and could result in retaliation impacting U.S. travelers abroad.

In summary, the U.S. members of the IAADFS oppose the Customs User Fee proposal in that it completely ignores the fact that Customs is already reimbursed for services provided to the airport duty free industry.

Testimony on
PROPOSED COAL EXCISE TAX INCREASE

Submitted to the
Committee on Finance
United States Senate

by
William E. Wall
Chairman of the Board
and Chief Executive Officer
KPL Gas Service
September 24, 1985

The Federal Black Lung program has laudable aims and the goal of getting the Black Lung Trust Fund on a sound financial footing is reasonable and necessary.

But, to aid victims of pneumonconiosis and their families by increasing an already burdensome tax that falls heavily on users of electricity is unwarranted. It is especially unfair to consumers in Kansas and other states which do not use coal from underground mines where black lung has been a problem.

Despite coal tax receipts of more than $500 million a year, and an increase in the excise tax funding the program in 1981, the trust fund is deep in debt and has had to borrow money every year since its inception.

Although the excise tax is technically imposed on coal companies, in reality it is paid primarily by Americans who use electricity. The coal companies pass the tax on directly to their customers dollar-for-dollar, pursuant to contract provisions. And nearly 80 percent of total domestic coal production is purchased by utilities who use the coal to produce electricity. Utilities in turn must pass the tax on to their customers as a cost of service. In Kansas this occurs immediately and automatically thru an increase in that portion of the customer's bill called the "Energy Cost Adjustment" (ECA). Hence, any increase in the excise tax actually represents a direct, penny for penny, increase in the cost of electricity.

If the proposed tax increase is enacted, Kansas customers of coal-burning utilities will pay nearly $50 million during the next five years toward the Black Lung Trust Fund -- an increase of $15.5 million above what they will pay under current tax rates.

It is important to note that pneumoconiosis is found almost entirely among miners who have worked in underground coal mines, which generally are located in the eastern United States. All coal used by Kansas utilities comes from surface mines located in the western United States, where exposure to black lung does not occur and never did.

Instead of increasing this unfair tax, alternatives which would work toward solving the financial problems of the Fund -- including forgiving the trust fund debt (or at least the interest on the debt) and gaining control over the cost of medical benefits under the program -- should be thoroughly explored.

If an increase in excise tax revenues must be effected, I suggest Congress recognize that America's electricity users are the principal payers, and deal more fairly with all of them. Rather than subject some of them -- those whose utilities burn western coal -- to an unjustifiable tax increase, Congress should consider broadening the tax base to include all fuel used in electric generation. Users of power generated from oil, from hydropower, from nuclear reactors or from natural gas are no more innocent of implication in pneumonconiosis than are users of power generated from surface-mined western coal.

BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

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MICHAEL D. ANTONOVICH

September 13, 1985

The Honorable Bob Packwood
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The County of Los Angeles Board of Supervisors is pleased to submit comments to the Senate Finance Committee on the subject of mandatory participation of state and local employees in Medicare and Social Security. The purpose of this testimony is to inform the Committee of the additional fiscal burden which will be placed on Los Angeles County and its employees because of mandatory coverage under Medicare and Social Security and to urge the Committee to reject any proposal which seeks such inclusion.

Los Angeles County opposes inclusion of its employees under Medicare and Social Security for the following reasons:

1. It represents a tax increase.
2. It constitutes a state and local government "bail out" of a troubled federal program.
3. It is an unnecessary intrusion of the federal government into the State and local government employee relations process.
4. It imposes a serious fiscal burden on State and local governments.

Budget proposals to include State and local employees under Medicare would escalate the County's costs by $25 million this year and would increase as the taxable salary base goes up. The imposition of Social Security on new hires would cost the County an estimated $4 million the first year.

County Operational Overview

Proposition 13, which started a nationwide tax limitation movement in 1978, left counties in California with no independent revenue raising authority. Since 1980,

-- Our welfare costs have risen 115%,
-- Our jail costs have risen 106%, and
-- Our court costs have risen 76%.

During that same time period, however, our local revenues have increased only 58% and our surplus has been totally exhausted. This is particularly critical for Los Angeles County because California counties must adopt balanced budgets and must end the fiscal year in the black.

The County's fiscal situation is bleak. For the second time in three years our adopted budget contains no funding for employee cost-of-living adjustments, simply because there is no money available. Several other new mandates and proposals at the federal level would create additional fiscal burdens on the county. These new mandates and proposals are:

-- The elimination of $80 million in General Revenue Sharing in FY 1987. All of the County's General Revenue Sharing funds are used to provide State-mandated indigent health care.

-- The application of the Fair Labor Standards Act to State and local governments will cost Los Angeles County up to $50 million in 1985-86 and may jeopardize some of our volunteer programs.

-- Immigration reform which provides for legalization but not full reimbursement for increased health and welfare costs would increase County costs by millions of dollars per year.

-- Changes in the federal income tax laws. The proposal to modify the rules governing public finance would impair our ability to finance public debt and reduce discretionary revenues by $20-$30 million per year. The proposal to eliminate 401(k) plans for public employees would impair our ability to reduce dependence on expensive defined benefit retirement plans.

Inclusion of all employees under Medicare and new hires under Social Security is an unnecessary intrusion of the federal government into the state and local government employee collective bargaining process. The following illustrates why we believe this to be true.

Background

No employee of the County of Los Angeles was covered by the Social Security System until July 1, 1964. At that time, all employees except safety employees were given the option of joining the system. After that date, all new employees except safety employees were mandated into the system. This action was the result of a change in California State law made applicable only to the County of Los Angeles. At the time of this action, the Social Security tax paid by the employer was 3.625% of the first $4,800 of the employee's salary and Medicare did not exist.

In 1974, after the County had been covered by Social Security for 10 years the tax rate had risen to 5.85% of the first $13,200 of the employee's annual salary and interest in withdrawal from the system was exhibited by both employees and the Board of Supervisors. In 1980, when the Board of Supervisors officially gave notice of its intent to withdraw from the Social Security System, the Social Security tax had risen to 6.13% of the first $25,900 of salary and when the County officially withdrew on December 31, 1982, the tax had risen to 6.70% of the first $32,400 of salary. The following table shows the scheduled tax in future years.

Calendar Year	OASDI & DI	Medicare	Total	Estimated Tax Base
1986	5.70	1.45	7.15	41,400*
1987	5.70	1.45	7.15	43,200*
1988	6.06	1.45	7.51	45,900*
1989	6.06	1.45	7.51	*
After 1990	6.20	1.45	7.65	*

* The maximum earnings subject to the tax increases each year in accordance with the increase in average earnings.

The 1982 County withdrawal from the Social Security System:

-- Eliminated duplicate employee benefits; and

-- Permitted use of savings for critical public services during a time of dwindling revenues.

Most pension experts suggest that income replacement upon retirement should be in the range of 60-80% of an employee's final compensation. Employees of the County of Los Angeles are covered by a State-mandated retirement system which provides for the employee to opt between a noncontributory and a contributory program. The contributory retirement program permits an income replacement level in excess of 80% without the addition of Social

Security and with the addition of Social Security permits income replacement in excess of 100% of final compensation. The costs of such a combined system are considered excessive and offensive by the tax paying public.

Retirees of the County of Los Angeles and their dependents are covered by a health insurance program, dental insurance program and vision insurance program. These programs permit the retiree to elect between indemnity and health maintenance coverage with the benefit structure of these programs being similar to those provided active employees.

County Benefit Package after Withdrawal from Social Security

During the period that we were withdrawing from the Social Security System, we negotiated with our employee organizations regarding the impact of the withdrawal. These negotiations concluded with an agreement to: (1) provide for all general employees a Long-Term Disability and Survivor Plan which provides a monthly disability benefit equivalent to 60% of an employee's salary, and a survivor benefit equal to 50% of benefits paid to the disabled employee; (2) establish a tax-deferred Thrift Plan wherein the County matches 50¢ for every dollar deferred by a participant to a maximum of 1% of the participant's salary; (3) establish a special Death and Disability Benefit Plan for persons employed on December 31, 1982 who die or become disabled and who are not eligible for Social Security solely because the County withdrew from Social Security. This Plan provides that the affected individual is covered by a County paid $15,000 life insurance policy and a County paid $75,000 Accidental Death and Dismemberment policy; (4) make the necessary changes to permit employee contributions to retirement to be tax-deferred; and (5) adjust the maximum subsidy for health insurance from $143.44 per month to $188 per month in 1983-84 and to $194.25 per month in 1984-85. The value of this package to employees excluding tax advantages is some $28 million annually, although to date the actual expenditures have been only $18 million annually.

Impact of Proposed Legislation

The proposal to cover all existing County employees with the Medicare program has a potential annual cost to the County of some $25 million. When one includes the cost to the employee, the cost is at least $50 million.

The additional cost of extending the entire Social Security program to only new hires is estimated at $4 million in just the first year. At such time as there is a full turnover of the work-force, the cost in today's dollars would be in excess of $140 million per year with an equal amount to be paid by the employees. This cost does not reflect already legislated increases in the tax rate or tax base.

Our current Memoranda of Understanding with employee organizations provides that only a minor portion of those benefits established in recognition of the County withdrawing from the Social Security system may be terminated should the County again be covered by Social Security. There is no provision which would compensate for the massive increase in mandated costs nor any provision to mitigate the impact of coverage for safety employees. Coverage of new employees by the Social Security System would again create duplicate employee benefits and reduce funds for critical public services.

Conclusion

In conclusion, the Los Angeles County Board of Supervisors urges the Senate Finance Committee to consider the fiscal impact on state and local governments of inclusion of state and local employees under Medicare and Social Security and to oppose any proposals in any form which seek such coverage.

Sincerely yours,

James C. Hankla
Chief Administrative Officer

JCH:ss

NATIONAL AIR TRANSPORTATION ASSOCIATION
4226 King Street • Alexandria, Virginia 22302 • (703) 845-9000

Founded
December 28, 1940

September 16, 1985

HAND DELIVERED

The Honorable Robert Packwood
Chairman, Committee of Finance
United States Senate
Washington, D.C. 20510

Dear Senator Packwood:

As the national representative of the nation's air taxi and fixed base operators, we would like to submit our views for the record on assessing fees for Customs services now being reviewed by the Committee.

The National Air Transportation Association (NATA) represents the business interests of over 1,000 fixed base and air taxi operations located on airports across the country. Typically, fixed base operators (FBO's) provide ground service and support to airlines, corporate flight departments and individual aircraft owners; on demand air taxis provide an important extension to commercial air transportation with highly-responsive and flexible air service. Since our members are an integral part of the aviation system, we are very concerned with attempts to impose fees for Customs services.

The function of Customs is to protect the public. Since users do not derive any special or direct benefit from the types of services required by statute to be provided by Customs, the proposed fees should not be imposed on the air traveling public. Rather, the general public should pay for the services as the ultimate beneficiary.

Charging these fees for Customs services is a form of double taxation. Ostensibly, it forces air travelers to pay twice for services without any additional benefit.

We are also concerned with the inequity of proposing such fees for air passengers and cargo at a higher level than that charged for arrival by other modes of transportation. Where is the logic of such punitive assessment? In fact, air taxi aircraft are already required to enter the country at specified airports to facilitate the inspection process, thus incurring additional cost and inconvenience.

The Honorable Robert Packwood
September 16, 1985

We realize the large deficit problem which must be dealt with by your Committee, and we can understand reviewing all possible revenue sources. However, in our view, Customs user fees are contrary to the established policy of those benefiting from a service being required to pay for the service. Our organization is opposed to customs fees and urges your Committee to reevaluate the Customs user fee proposal.

Thank you for the opportunity to explain our position on this issue.

Sincerely,

BD Draughon

B. D. Draughon
Director of Operations &
Regulatory Affairs

The National Association of
Private
Psychiatric
Hospitals

1319 F Street, NW, Suite 1000, Washington, DC 20004 • 202-393-6700

September 23, 1985

The Honorable Robert Packwood
Chairman, Senate Finance Committee
259 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

As your committee prepares to markup its deficit reduction package for fiscal year 1986, I want to bring to your attention three issues of particular interest to private psychiatric hospitals:

I. MEDICARE PAYMENT INCREASE

On July 23, 1985, the House Ways and Means Committee approved the recommendation of the Health Subcommittee of a 1% Medicare payment increase for both PPS and PPS-exempt hospitals. The Health Subcommittee markup was on July 15, 1985. Unfortunately, the Chairman of the Health Subcommittee, Pete Stark (D-9th-CA) did not have the benefit of the attached ProPAC July 18, 1985 correspondence which urged a higher payment increase for PPS-exempt hospitals.

ProPAC is a very credible source of information and is well-respected on the Hill. ProPAC was created by Congress in 1983 to make recommendations to the Secretary of Health and Human Services (HHS) on the appropriate percentage change for Medicare payment. To assure the credibility of this recommendation, Congress required ProPAC to take into consideration changes in the hospital market basket, hospital productivity, technological and scientific advances, the quality of health care provided in hospitals, and long-term cost effectiveness in the provision of inpatient hospital services. After going to this length to assure that ProPAC recommendations were based on relevant criteria, Congress required the Secretary of HHS to take ProPAC recommendations into account before establishing the percent of change in

September 23, 1985
Page Two

the Medicare payment.

NAPPH requests that you approve a proportionately higher Medicare increase for PPS-exempt hospitals based on the July 18, 1985 ProPAC letter. We urge you to take ProPAC's recommendations into consideration before setting a new Medicare payment rate.

II. APPLICATION OF THE 190-DAY LIFETIME LIMIT ON PSYCHIATRIC CARE IN FREE-STANDING PSYCHIATRIC HOSPITALS TO PSYCHIATRIC UNITS OF GENERAL HOSPITALS (SECTION 106 OF S. 1550)

Section 106 of S. 1550, the "Health Care Financing Cost Reduction Amendment of 1985", introduced August 1, 1985 by Senator Durenberger at the request of the Administration, has not been shown to reduce costs in the Medicare program. Data is not available to project a cost increase or decrease. Thus, Section 106 could just as likely increase costs as reduce them. If costs would be reduced, this would indicate a reduction in Medicare benefits. If costs would be increased, Medicare benefits would be increased.

NAPPH does not believe that Section 106 should be considered until cost estimates are completed and the number of Medicare recipients affected determined.

III. ELIMINATING THE RETURN ON EQUITY (ROE)

In light of the ROE legislative history, NAPPH does not believe that your committee should, at this time, take up the subject of eliminating the ROE from the Medicare payment currently being made to hospitals. The Congress, in the Social Security Amendments of 1983, specifically required the Secretary of the Department of Health and Human Services (DHHS) to study, develop and report to Congress on methods and proposals for legislation by which capital-related costs "such as return on net equity" can be included in the prospective payment system. To date, DHHS has not reported to Congress, and the intent of Congress was clear that ROE should be addressed with other capital-related issues. The Medicare ROE and other capital issues are complex parts of an important area of reimbursement and should not be changed prior to careful study.

However, if one were to judge the issue on its merits today, NAPPH would suggest that ROE and interest payments be treated in the same manner. It makes no sense for Medicare to reimburse, as it currently does, for interest expenses associated with capital expenditures by hospitals and not reimburse the investor-owned hospitals that finance the same capital expenditures through an equity offer.

Why would Medicare treat these two finance mechanisms differently when their function is the same? Medicare's ROE payment is identical in principle to the payment of interest to people who have loaned money to not-for-profit hospitals. ROE is not a "profit", but rather, like interest, ROE is a cost. Simply put, both interest and ROE are payments to the suppliers of capital for its use. The owners of debt capital and the owners of equity capital are identical in that both are suppliers of an essential resource and thus are entitled to a return for the use of that resource.

If you didn't pay interest on a debt, you would be using that person's money without paying for it. Failure to pay a return on equity would have the same effect--and who would buy stock if they did not anticipate a reasonable return? If a reasonable return was not forthcoming, that source of financing would soon dry up, resulting in an increased demand to borrow money which could cause an increase in loan interest rates. Tax-exempt financing would cost more and, in turn, cost the Medicare program more.

The elimination of ROE would place investor-owned hospitals at a clear disadvantage. Specifically, the investor-owned hospital pays corporate, federal and state income taxes on its net income which reduces the Medicare ROE payment by about 41%. (Corporate dividends paid to its stockholders resulting from a return on equity are taxed as personal income to those shareholders.) In addition, investor-owned hospitals also pay state and local property taxes. There are still other tax disadvantages. For example, the investor-owned hospital may not issue tax-exempt securities to finance capital expansion or replacement and may not receive grants and tax-deductible gifts.

NAPPH believes that there should be linkage between Medicare reimbursement policy and tax policy. Since this is a complicated area, segments should not be addressed in isolation. An in-depth study to look at

September 23, 1985
Page Four

the entire capital issue is required. Any policy decision reflecting the findings of that study should embody a transition phase-in period which is long enough to satisfy the concerns of the investment-banking community.

I appreciate your consideration of NAPPH's views on these important issues and look forward to working with you to make the changes we have suggested.

Sincerely,

Robert L. Thomas
Executive Director

RLT:smp

encl.

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION
300 7th Street, S.W. Washington, D.C. 20024 (202) 453-3986

Stuart H. Altman, Ph.D.
Chairman

Donald A. Young, M.D.
Executive Director

RECEIVED
JUL 19, 85
WAYS AND MEANS
HEALTH SUBCOMMITTEE

July 18, 1985

Honorable Fortney N. (Pete) Stark
Chairman, Health Subcommittee
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Stark:

Thank you for your July 16 letter regarding the Commission's recommended change in fiscal year 1986 payment rates for psychiatric, rehabilitation, and long-term care hospitals. I am pleased to have the opportunity to clarify the Commission's recommendation on the update factor for these hospitals.

The Commission believes the update factor for exempt hospitals and exempted distinct part units should differ from that for PPS hospitals for two reasons. First, since substantially more of the expenses in psychiatric, rehabilitation, and long-term care hospitals are for labor than in other hospitals, separate market basket weights should be used for this group. Children's hospitals were not included in this group because their pattern of expenses is similar to PPS hospitals.

Second, because exempt hospitals are not paid on a case-mix basis, their update factor should not be adjusted for case-mix change. The zero update factor for exempt hospitals proposed by the Administration is largely justified by an offset for case-mix change, which should not apply to exempt hospitals.

For fiscal year 1986, the Commission recommended that exempt hospitals and PPS hospitals receive the same minus one percent adjustment for productivity and changes in technology. In the future, a separate adjustment may be developed for exempt hospitals. The Commission's recommended update factor for the exempt hospitals would be 3.3 percent, excluding the differences which might result if a separate market basket were used for exempt hospitals.

This compares to 2.1 percent for PPS hospitals. (See enclosed table.) We expect that use of a separate market basket would result in a small difference in the update factor.

I hope this information is useful to you. If I can be of further assistance, please feel free to let me know.

Sincerely,

Stuart H. Altman
Chairman

Enclosure

TABLE 1

ESTIMATED INCREASE IN PPS PAYMENT AMOUNTS FOR FISCAL YEAR 1986: COMPARISON OF NPRM TO PROPAC RECOMMENDATION

	NPRM	ProPAC
FY 86 market basket increase	4.85%	4.85%
Previous market basket forecast errors	-1.30%	-0.57%[a]
Policy Target Adjustment Factor (DAF)	-1.50%	-1.00%
Components:		
Productivity	-1.0%	-1.5% to -2.0%
Cost-effective technologies	1.5%	1.5% to 2.0%
Product change		-1.0%
Cost-ineffective practice patterns	-2.0%	
SUBTOTAL (market basket plus DAF)	2.05%	3.28%[b]
Observed change in case mix	-4.90% (1981-1985)	-2.00%[c] (1985 only)
Real case-mix change during FY 85	0	0.80%[d]
TOTAL	-2.85%	2.08%
PROPOSED INCREASE	0	2.08%

---

[a] The Commission recommended that errors in forecasting internal price proxies (the wage component of the market basket) should not be corrected. The estimate of -0.57% (44% of -1.3%) assumes that the magnitude of the forecast errors was about the same for wages as for other price change measures.

[b] This is the update recommended for exempt hospitals, excluding the differences due to the use of separate market basket weights.

[c] ProPAC estimate based on the findings of the Rand study cited in the proposed rule. The 2% increase in observed case mix for fiscal year 1985 is based on Rand's estimate of a 0.5% quarterly increase in case mix after hospitals have switched to PPS.

[d] The 0.8% increase estimated here for fiscal year 1985 takes into account historical trends in real case-mix change, recent shifts to outpatient treatment, and within-DRG case-mix changes that would not show up in the case-mix index.

Statement of the

National Association of Stevedores

Presented to the

Committee on Finance
United States Senate

on

Customs Service User Fee Taxes

Submitted by

Thomas D. Wilcox
Executive Director and General Counsel

National Association of Stevedores
2011 Eye Street, NW
Suite 601
Washington, DC 20006

September 11, 1985

The National Association of Stevedores (NAS) is a membership trade organization representing the United States stevedore and marine terminal industry. NAS member companies employ tens of thousands of longshore labor to load and unload ships calling at this country's ports in both foreign and domestic commerce. NAS member companies do business on all of the nation's seacoasts, the states of Alaska and Hawaii, the Commonwealth of Puerto Rico, and various inland ports.

"User fees" are of particular concern to the stevedore/ marine terminal industry because they will have a direct impact upon United States commerce. Ninety-five percent of this nation's international commerce is waterborne. The ships which transport this commerce to and from U.S. ports must be loaded and unloaded by stevedore and marine terminal companies, and the labor they employ. Added costs will adversely affect the flow of commerce. For example, with U.S. exports, added cost will make them less competitive in the world market to the detriment of the American producer, the stevedore/marine terminal industry, and other industries which serve or depend upon waterborne commerce.

First of all, let's call a spade a spade. A fee is a fee, a tax, a tax. The sole purpose of the proposals to impose Customs Service "user fees" is to raise additional revenue to reduce the federal budget deficit. These "user fees" are taxes. Are they warranted? The NAS reply is no, because they do not address or cure the cause of the budget deficit and because they are an additional cost, an additional burden on U.S. international commerce.

No matter how "identified" or "defined", American commerce and the American consumer will pay these fee taxes. It is the American consumer of imported products that benefits from imports and it is the American consumer that creates the need for Customs' services, not the transportation industry, importers, or Customs House brokers. If the American consumer did not purchase imports, there would be no need for Customs' services for which proposed fee taxes are sought.

However, American consumers do purchase imports; the transportation system does deliver them; and the Customs Service does provide the necessary clearance and tax collection services at ports of entry. Historically, all taxpayers have paid for Customs' services, as all taxpayers have benefited from them. Also, Federal revenue raised by the Customs Service already far exceeds the cost of collection by several billions of dollars annually.

Another aspect of user fee taxes is the negative effect on American exports. The world is composed of interdependent economies which is the essence of why we trade. A tax on imported goods also affects exports because many American exporters use imported components. This raises the price of

American exports and reduces their competitiveness.

If the Congress determines that the imposition of Customs' Service user fee taxes is unavoidable, then the NAS urges that the Congress enact the user fee tax adopted by the House Committee on Ways and Means in its Deficit Reduction Amendments of 1985, H.R. 3128 reported out July 31, 1985 (House Report 99-241, Part I). The Ways and Means proposal described at page 8 of its report and stated as Section 214(a) of the bill (House Report pages 176-177) appears to be the most palatable and least discriminatory and would, over a three year period, raise $650 million additional Customs revenue. These additional temporary burdens on commerce would be the least onerous and also would require Congressional approval after three years to remain in force.

The Administration's proposal -- as explained in the letter of July 17, 1985 from the General Counsel of Treasury to the President of the Senate and the Speaker of the House of Representatives, and as introduced by request as H.R. 3058 -- is unacceptable. It was rejected by the House Ways and Means Committee, and we urge the Senate Finance Committee to reject it also.

NAS concerns about the Administration's proposal are two-fold. First, section I of the Administration's proposed bill would add a new section 525 to the Tariff Act of 1930 (19 U.S.C.

1202 et seq.). This would give the Secretary of the Treasury permanent authority to impose fees for the processing of aircraft, vessels, and merchandise arriving in or departing from the United States, in order to reimburse the Government for all costs of collection of revenue, inspection of passengers and merchandise, and administration of commercial activities. The Secretary could impose these fees on any person or entity and could change the fees periodically.

The NAS believes that the Administration proposal would be an unconstitutional delegation to the Executive of Congress' power to tax commerce and would tax it in such a way that the taxpayer has no redress. Although the Treasury letter states "The relationship between the user fees and the services provided by Customs will be clearly reflected in the narrative of the President's budget," how can one challenge its basis? If any user fee tax is to be assessed, Congress must assess it; Congress must define the service for which the user fee tax is to be paid; and Congress must decide who is to pay. This the Ways and Means Committee has done and we urge the Finance Committee to do the same.

Secondly, the NAS fears that there is more to the proposal than meets the eye. For some time Treasury has been urging a reimbursement plan for small ports of entry. Under this plan ports of entry which Customs determines to be too small to justify Customs services would have to pay for the services provided, or go without any Customs Service. The proposal was discussed when the Finance Committee heard Customs testimony earlier this year and was advanced by Customs in testimony before the Ways and Means Committee on June 19, 1985. Customs does not have the statutory authority to require "underutilized ports" to reimburse it for its services (House Report page 58) and that authority was not given to it by the Ways and Means Committee. Customs does have statutory authority to close ports of entry, but that authority was limited in the House bill (House Report pages 58 and 178).

Although the Administration's letter of July 17, 1985 and the draft bill submitted with it do not refer specifically to the "underutilized port" reimbursement concept, proposed section 525 certainly does not prevent the Secretary from implementing such a scheme. That section, as noted, is silent as to the manner or rationale that the Secretary of Treasury could use to set fees other than that they be sufficient to reimburse the Government for all costs. That could mean transportation, food and lodging for Customs inspectors' travel from a "utilized port" to or from an "underutilized port" where a service (inspection) is to be performed. In fact, there is nothing in the Administration's proposal that gives any assurance that each type of "user" would pay the same fee tax for like service rendered by Customs.

Implementation of the "underutilized port reimbursement" scheme will directly affect many members of the NAS and the port communities in which they do business. Denial, delay, and/or extra cost of Customs services would lead to the loss of import cargoes at the Customs-designated "underutilized port." Denial means a re-routing of imports to those ports which have better Customs services and lower costs. And what recourse does the "underutilized port" have? None, except to persuade his elected representative to persuade Customs to remove his constituent port from the "underutilized port" list. The number of ports is significant. Of the 190 seaports Customs now identifies as ports-of-entry, 120 have been mentioned by Customs as "potential reimbursable ports." Fortunately, the Ways and Means Committee bill will prevent Customs from imposing special fees on all of those 120 and from closing down most of them during fiscal year 1985 (House Report page 178).

The NAS urges the Congress, if it determines that a Customs Service user fee tax must be enacted, to assure that Congress (1) sets the fee tax and defines the services for which the fee tax is to be paid, (2) defines which entity (user) pays which fee tax, and (3) requires that all services, wherever provided, are assessed the same fee tax regardless of the size of the port or the frequency on which the service is provided. The NAS objects to the concept of a Customs Service user fee tax, but if such a tax is to be imposed it must be non-discriminatory.

In conclusion, we wonder whether the proverbial left hand knows what the right hand is up to. In other water-related bills, H.R. 6 and S. 1567, there is a proposal to impose a .04 percent ad valorem tax on imports and exports. The NAS opposed this tax because, again, it does not address the fundamental problems of the budget deficit, and it is an added burden on commerce. In addition, the taxing of exports is unconstitutional and further reduces their competitiveness. And if it were imposed, how would it be collected? By Customs? If so, how? Is anyone assessing the cumulative impact of all these proposed user fee taxes? In a brief period Congress is considering various user fee proposals. We respectfully urge you to be aware of the user fee tax burden on U.S. commerce and to consider whether the nation can sustain it.

NATIONAL COAL ASSOCIATION

STATEMENT OF

JAMES G. RANDOLPH
PRESIDENT
KERR-MCGEE COAL CORPORATION

on behalf of

THE NATIONAL COAL ASSOCIATION

before the

COMMITTEE ON FINANCE
UNITED STATES SENATE

WITH REGARD TO

THE BLACK LUNG DISABILITY TRUST FUND

SEPTEMBER 13, 1985

I am James G. Randolph, President of Kerr-McGee Coal Corporation. Kerr-McGee is based in Oklahoma City and is a producer of both surface and underground mined coal. We have operations in Illinois, Wyoming, and in 1984 we produced in excess of 15 million tons. I am appearing today on behalf of the National Coal Association whose members constitute the producers and suppliers of most of this nation's bituminous coal. We appreciate having this opportunity to present our views on the Black Lung Trust Fund, the excise tax which supports the Fund and the impact of that tax on the price and competitiveness of coal.

We have appeared before House and Senate committees on previous occasions seeking reform of the black lung program. Regrettably, the result of most of these reform efforts has not been entirely beneficial. What began as a justifiable effort to compensate victims of pneumoconiosis not covered by state programs had, prior to 1981, been transformed into a federal supplemental pension program rather than an occupational disease compensation program. Only since enactment of the Black Lung Reform Act Amendments of 1981, has the program achieved what it was originally intended to be, a workers compensation program providing benefits to those suffering from pneumoconiosis.

Let me state unequivocally that it is this program which we in the coal industry continue to support. This was the intent of the original legislation adopted by the House in 1969; however, without a foundation of supportive medical evidence but with an all too familiar mixture of pork barrel politics and social reformer zeal, the legislation was broadened in conference to provide benefits to those not truly deserving. It is somewhat ironic that today those whose eligibility was established on less than sound medical evidence jeopardize the position of legitimate claimants where eligibility is beyond question.

In 1981 the coal industry joined with the United Mine Workers of America (UMWA) and the administration in support of a package of amendments which were intended to:

(1) base future entitlement on workers compensation criteria rather the employment criteria; and (2) "temporarily" double the black lung excise tax to bring the Trust Fund into financial solvency. While the amendments have succeeded in significantly reducing the prospective approval rate for new claimants, they failed to address that category of claims which cause the problem now being experienced by the Trust Fund; namely, those claims which were reconsidered and subsequently approved under the more liberal eligibility criteria which the Congress adopted in 1977. As a result, the Trust Fund remains in deficit and the Labor Department's 1981 projections of solvency, on which the tax increase was based, have been proven unreliable and largely groundless.

Before addressing the dilemma facing the Department of Labor (DOL), let me briefly review the black lung program and how we got to where we are today.

Overview of the Black Lung Act and Reform Amendments

The federal black lung program was initiated in 1969 as Title IV of the Coal Mine Health and Safety Act. It was designed to provide benefits to miners totally disabled due to pneumoconiosis arising out of coal mine employment and to survivors of miners whose death was due to the disease. At its inception, its sponsors characterized it as a limited "one-shot" effort aimed at only those who truly suffer an occupation-related disability. Its sponsors assured their colleagues that:

> "We are only taking on those who are now afflicted with pneumoconiosis in its fourth stage -- complicated pneumoconiosis..."[1]

The bill was introduced and enacted at a time when few states compensated disabled victims of pneumoconiosis and when no state provided compensation to miners or survivors of miners who had retired from mining prior to enactment of the state law.

In 1972, Congress greatly expanded the eligibility criteria of the Act by adding a new presumption of eligibility based simply on coal mining employment of 15 years or more, by extending eligibility for benefits to survivors of miners who died from causes

[1] Remarks of Hon. John Dent, page H-10047, Congressional Record, (Oct. 27, 1969).

other than pneumoconiosis, and by making several additional changes in evidentiary and eligibility requirements. The new fifteen year presumption was of particular concern to the industry because no medical evidence had shown a clear causal relationship between duration of employment and the incidence of disability due to pneumoconiosis.

Against this background, Congress in 1977 amended the Act for a second time again expanding the eligibility criteria so that virtually any employee with respiratory distress could qualify for benefits. Further, by expanding the employment based presumptions, an employee did not even need to be suffering from anything but rather had to have worked in the mines for a specified number of years. This was achieved through the addition of an irrebutable 25-year presumption. Also, Congress limited the government's ability to re-read x-rays but also and most importantly directed the Labor Department to re-examine all claims which had been denied prior to March 1, 1978 under the new eligibility criteria. In order to pay for this largess Congress created what was to be a self-financing trust fund, the Black Lung Disability Trust Fund, financed by a per ton excise on domestic coal production. The following table indicates how critical this last point is within today's context:

Category	Approval Rate
o pre-1977 claims	3% of all claims filed
o claims subject to the review under 1977 Amendments	45% of all claims re-examined
o claims adjudicated under 1977 Amendments, prior to 1981 Amendments	14% of all claims filed
o claims adjudicated under the 1981 Amendments	5% of all claims filed

The claimants subject to review under section 435 of the Act as amended in 1977 had previously been denied benefits under the Act for lack of sufficient medical evidence of impairment prior to the 1977 amendments. This re-examination of some 125,229 cases resulted in the approval of 56,957 claims. To reiterate, 45 percent of previously denied claims were determined to be eligible for benefits from the Trust Fund as a result of the 1977 amendments. This is the single greatest factor leading to the difficulty currently being experienced by the Trust Fund. In simple terms, this congressionally mandated re-review of previously denied claims was the straw that broke the camel's back effectively bankrupting the Trust Fund.

The 1981 Amendments

In 1981, the Congress as well as the coal industry became concerned with the financial integrity of the Black Lung Disability Trust Fund. Since the inception of the Trust Fund in 1978, outlays had exceeded income from the coal excise tax by $1.2 billion, with the difference being made up by advances from the Treasury. To remedy the situation, the administration, the coal industry, the UMWA and the Congress embraced a legislative compromise intended to put the Trust Fund on the road to financial solvency while at the same time eliminating the questionable eligibility criteria. Further, the amendments directed the Secretary of Labor to initiate two studies and report legislative recommendations to the Congress within 18 months. I might add that on this latter point, the congressionally mandated medical study on the state of the medical science concerning the diagnosis of pneumoconiosis and the relationship of simple and complicated pneumoconiosis to physical impairment and economic disability has yet to be delivered to the Congress, even though it was due in July 1983. We urge this Committee to direct the Secretary to report to the Congress on its findings.

The Need For Congressional Oversight

With the foregoing background one must ask what has transpired since enactment of the 1981 amendments and why the program must again be reviewed. As previously indicated, the 1981 Amendments have had a dramatic impact on the approval rate for those claims first filed after enactment, namely, a reduction from an approximately 14 percent approval rate for claims adjudicated under permanent part 718 criteria (used for all new claims) to slightly under 5 percent today. However, while this side of the equation has lived up to expectations, the other side, the financing needs of the Trust Fund have worsened.

When one considers that there are currently nearly 97,000 claimants receiving benefits out of the Black Lung Trust Fund and that 56,957 claims were approved under the 1977 amendments, it becomes obvious that the Trust Fund's shortfall and indebtedness can be almost entirely attributed to the expanded eligibility criteria which were adopted under the 1977 amendments and the re-review of previously denied claims. In other words, more than half of the claims approved were made during 3 years of the program's 15 year existence. The law as it applies to new claimants is working well. The 1981 amendments corrected the overexpanded eligibility criteria created in 1977. The approval rate today is a realistic 5 percent. The program is now designed as the occupation-related disability program which Congress originally intended it to be, as opposed to what it effectively became in 1977 -- an income transfer program for a selected, narrow group of citizens. Yet, the program continues to include a large number of claimants who were not intended to be beneficiaries under the original or the current aims of the program and who would not qualify for benefits if they were subjected to the '81 Amendments.

The 1981 Amendments imposed a "temporary" doubling of the black lung excise tax from $.50 and $.25 per ton for underground and surface coal respectively to $1.00 and $.50 per ton. The DOL projected at that time in a letter from then Secretary of Labor Donovan to the Education and Labor Committee: "This legislation provides a solution to the long-term problems of the Fund, and should obviate the need to constantly revisit this matter each time there is a change in coal production or the economy in general." Now, within four years of that statement, we find the Administration proposing that the excise tax be increased once again.

In its FY 1986 budget message, the Administration proposes to deal with the black lung problem raising an additional $235 million from the coal industry. This would be accomplished by: (1) increasing the current excise tax by 50 percent to $1.50 per ton for underground coal and $.75 per ton for surface mined coal; (2) increasing the 4 percent sales price limitations; and (3) temporarily freezing monthly benefits. If adopted, DOL projects the Trust Fund would be solvent by FY 1999. The first two components of this proposal were included in the deficit reduction amendments which the Ways and Means Committee adopted prior to the August recess. We consider this to be wholly inequitable and unacceptable.

The practical problem of attempting to solve the problems confronting the black lung trust fund through an excise tax increase is seen by the experience since the last time it was attempted, in 1981. While facing a similar revenue shortfall, the government and others projected robust growth in coal production sufficient to "close the gap" by the 1990s. Instead, growth in coal production stagnated, minemouth prices declined nearly 20 percent in real terms, and Trust Fund borrowing is now to the level that a fifty percent tax increase is necessary to again "close the gap" by the 1990s. Yet the prospects for increased coal production to provide the needed revenue for the next decade are far more clouded than in 1981. With equilibrium being reached in the energy market and flat world oil prices predicted, coal is facing not only intense competition from domestic gas, but imported coal as well as Canadian electricity imports. Further excise tax increases not only debilitate coal's ability to compete domestically, but severely restrict coal exports to other countries, where competition is razor sharp. In short, no one knows what tax increase would actually cover the projected shortfall.

Mr. Chairman, the black lung program has historically been wrought with abuse. The General Accounting Office and the Inspector General have issued numerous reports criticizing the Department over the administration of the program. Yet, once again we find ourselves opposing what many perceive to be our responsibility. We have and continue to assume more than our fair share of the cost of the black lung program and urge this Committee to reject the Administration's request. I would like to point out that in addition to the excise tax, individual coal companies pay for claims for which we have been identified as the responsible operator.

The black lung program has been in existence for 15 years. Unfortunately, DOL has not yet developed an accurate data base for the program from which realistic projections about future program expenditures and receipts can be made. Recently, the Department was presented with an independent review of only the population and benefit outlay sections of the Trust Fund model (copy attached). The review concluded that the model may be overstating expenditure needs by as much as 10-20 percent. Clearly, this indicates that if the model is to be used as a credible representation of likely revenues and benefit outlays, it must first be subject to peer review and that any discrepancies must be rectified.

The U.S. coal industry objects to the imposition of an additional monetary burden to fund a program which provides payments to individuals who are not medically deserving. We believe this objection is justified when one considers that in 1981 the coal industry and our customers were promised that this tax burden would decrease over time, rather than increase as is now proposed. The simple fact is the reason for the insolvency is the excessively liberal criteria used to qualify individuals for benefits prior to 1981. Prior to that time Congress structured the program to provide benefits to the maximum number of claimants irrespective of disability. It is now time to face that reality and initiate actions to cure the woes of the Trust Fund without limiting our ability to compete in both domestic and international markets.

Mr. Chairman, the Black Lung Benefit Program requires careful scrutiny to determine where and why the errors were made. We suggest that the major problem with the program is the inclusion of 56,957 benefit recipients, many of whom this program was never intended to include - as the administration's proposed excise tax increase would do - to underwrite a supplemental employee benefits program for a narrow group of people and to compensate for the DOL's apparent inability to accurately project the costs of the program. The coal industry and its customers should not be held responsible for this. In addition, you have before you major tax reform legislation which we will and have been addressing at other hearings. The provisions contained in that proposed tax package combined with the proposed increase in the black lung excise tax will significantly alter the coal industry's ability to compete not only with other forms of energy but also with foreign competitors in the coal market.

There are many questions the Congress must address and evaluate prior to enacting yet another tax increase. The potential impact of any program changes on the program's beneficiaries, future domestic production and employment in the coal industry, and regional and international industry restructuring that would result from an increase need to be assessed.

The financial insolvency problem seems to present only three solutions; increase the tax, as the administration suggests; re-examine previously approved claims applying the 1981 criteria; or treat the benefits program as a supplemental pension program and restore solvency by excusing some portion of the Treasury advances. Either of the first two alternatives would restore solvency. However, the political unpopularity of the second choice — re-examination of claims, is no reason to embrace the first. Re-examining prior claims does not mean denying benefits to those who legitimately qualify- and we all agree on appropriate compensation for victims of occupational hazards. While some may find re-examination to be politically infeasible we would argue that increasing the tax in todays environment is equally economically infeasible.

The third option is to acknowledge in legislation that the Trust Fund, which is liable for pre-1970 employment cases and instances where no employer-defendant can be found, is in fact no more than a transfer payment for largely welfare purposes and that it should be financed in the same way the earlier program was: from general revenues. In this option, the current $2.5 billion deficit of the Trust Fund would be excused. The current tax on coal producers and consumers would continue until the Fund is solvent.

(The number of beneficiaries will decline significantly after 2000.) What would change is that a tax increase would not be necessary to finance borrowing to cover an ever spiraling debt, a tax increase that is self-defeating. Combined with this option of excusing either the Trust Fund deficit or interest payments to the fund would be continued tight administration of the program by the Labor Department, where the approval rate for new claims has dipped to below 5 percent since 1981.

Mr. Chairman, the choice before this committee is not an easy one. We can continue the policies of the past or use this opportunity to steer a new course for the Trust Fund which will place it on sound financial footing while assuring that those who are truely needy recieve their just compensation.

The nation's coal mines are cleaner and safer than in the days that lead up to establishment of the black lung program. For all of its faults and despite its somewhat sordid history, the current program enjoys widespread support. The goal for Congress and the administration in the mid-1980s is to set on a sound and equitable financial basis the federal government's one foray into an occupation disease compensation program. An excise tax increase on coal production and consumption will not accomplish that goal. On behalf of the NCA, I want to thank this Committee for the opportunity to present this testimony on the Black Lung Disability Trust Fund. We will be happy to provide further comment and assistance to the Committee members and staff, as well as respond to any questions which they may have.

TESTIMONY ON THE
PROPOSED REPEAL OF THE TAX-EXEMPTION FOR
NONPROFIT HEALTH CARE FACILITIES BONDS

Submitted by

National Council of Health
Facilities Finance Authorities

To

The Committee on Finance

of the

United States Senate

September 25, 1985

STATEMENT

I. Introduction

My name is George C. Phillips, Jr. I am the chairman of the National Council of Health Facilities Finance Authorities. The Council is an association of 25 state and local authorities that issue bonds principally on behalf of nonprofit health care facilities. I also am the Executive Director of the Illinois Health Facilities Authority, located in Chicago.

The health facilities finance authorities were created by state legislation, and their boards of directors were appointed by the executive or legislative branch of their state or local governments, to further the public purpose of providing quality health care. Generally, this is done by issuing tax-exempt bonds on behalf of private nonprofit health care institutions. These authorities issue a substantial amount of the tax-exempt bonds issued on behalf of nonprofit health care facilities. For this reason, the National Council is well aware of the capital needs of these institutions and their ability to attract capital and pay for it.

The proposed repeal of the tax-exemption for nonprofit hospital bonds should be considered in the context of other tax reform proposals and other changes in federal policy which also would adversely affect nonprofit hospitals. This proposal should be evaluated not only in terms of tax policy but also in terms of health policy.

As a substantial group of issuers, we believe that the proposal would have an immediate adverse effect on nonprofit hospitals that require capital and a cumulative, long-term adverse effect on the nonprofit hospital sector and the health care system as a whole. The repeal of the tax-exemption for hospital bonds is not justified by the rationale for this proposal or by any possible benefit to the Treasury or the economy. The National Council, therefore, urges Congress to provide a measure of stability for the continuation of the tax-exemption for hospital bonds and to provide a measure of stability for the continuation of the nonprofit hospital sector of our health care system.

II. Perspectives on Nonprofit Hospitals

A. The Nonprofit Hospital Sector

Health care in our country traditionally has been conducted in major part through community-oriented nonprofit and public hospitals. These institutions have been created, sponsored, supported, and directed by our communities. Public hospitals exist because of state and local governments' basic and traditional responsibility for ensuring public health. Private, nonprofit hospitals exist to supplement public institutions, because communities have recognized that the health of their members transcends economic and social differences and is of concern to all.

Private nonprofit hospitals are the voluntary response to the health care concerns of our communities. Most of our nations' health care is performed in nonprofit hospitals. In 1983, there were 3347 nonprofit hospitals. These hospitals constituted 60 percent of our nation's community hospitals (nonfederal, short-term, general hospitals) and 70 percent of all community hospital beds.1/

However, the value of nonprofit hospitals to their communities must be measured not only in terms of how much care they provide, but also in terms of the kinds of care they provide. The nonprofit sector provides certain socially desirable but generally unlucrative hospital services far in excess of its proportion of all community hospital facilities. These services include burn centers, rehabilitation outpatient services, alcoholism and drug dependency outpatient services, emergency psychiatric services, and hospice care. They also provide a disproportionate amount of services on the forefront of medical technology, such as organ transplants, open-heart facilities, radiation therapy, and genetic counselling.2/ And they perform these services very efficiently. It has recently been reported that nonprofit hospitals' charges are 21 percent lower than proprietary hospitals' charges.3/

Nonprofit hospitals also serve most of our nation's Medicare, Medicaid, and indigent patients. Nonprofit hospitals account for three-quarters of all Medicare services, over one-half of all Medicaid services, and over one-half of all uncompensated care.4/ Moreover, most of our nation's medical education and research is conducted in nonprofit hospitals.

B. Financing Nonprofit Hospitals

The public purpose of our nation's nonprofit hospitals has long been reflected in the public support for nonprofit hospital financing. Prior to World War II, nonprofit hospitals were financed primarily by charitable contributions and local government assistance. The Hill-Burton program provided federal grants, low interest loans, and loan guarantees for nonprofit hospitals from 1946 to the late 1970s. Section 242 of the National Housing Act was enacted in 1968 to provide mortgage insurance for certain nonprofit hospitals. The Farmer's Home Administration has a low interest loan program for rural hospitals. Hospital capital expenditures are also supported by the federal and state governments through the Medicare and Medicaid programs, which provide reimbursement for capital costs.

Finally, state and local governments have established health facilities financing authorities to issue tax-exempt bonds primarily for nonprofit health care institutions.

Today, most financing for nonprofit hospitals is tax-exempt debt. However, hospital bonds account for a rather small and decreasing percentage of all tax-exempt financing. In 1984, nonprofit hospitals accounted for about 10 percent of the $100 billion in total tax-exempt issues. In recent years, this percentage has steadily declined. It was about 13 percent in 1982 and 12 percent in 1983. For the first quarter of 1985, it was about 9 percent.[5]

This capital was used for health facilities modernization, renovation, and replacement, for bed reduction and expansion, for equipment purchases, and for refinancing existing debt. Contrary to a popular misconception, most of this capital was not used for bed expansion. In 1984, 61 percent of the dollar amount and 69 percent of the number of all tax-exempt hospital bonds were used for a purpose that did not result in an increase in the number of beds.[6]

III. The Tax-Exemption for Nonprofit Hospital Bonds Should Be Preserved

A. Adverse Impact of the Proposal

1. Proposed and Implemented Federal Policy Changes Adversely Affecting Nonprofit Hospitals

Other elements of the President's tax reform proposal, in addition to the proposed repeal of the tax-exemption for nonprofit hospital bonds, would adversely affect nonprofit hospitals, and should be considered in assessing the impact of this proposal. The repeal of the charitable deduction for taxpayers who do not itemize, the inclusion of the unrealized gain on gifts of appreciated property as a tax preference for the purpose of the minimum tax, and the reduction in marginal tax rates would adversely affect nonprofit hospitals by reducing the amount of capital they receive from charitable giving. The reduction in charitable giving that would result from these changes has been estimated to be 17 percent.7/

In addition to these tax law proposals, the federal government has proposed reductions in hospital reimbursement generally, and specifically for capital expenses. The proposed repeal of the FHA section 242 federal credit insurance program for hospitals also would adversely affect the ability of nonprofit hospitals to raise capital, especially in states with stringent rate setting.

These proposals come on top of the new prospective payment system (PPS), which already has sharply reduced revenues for many hospitals. The PPS also effectively requires hospitals to raise additional capital to restructure their facilities in order to operate in a more efficient manner. Ambulatory care centers and surgi-centers are examples of hospitals' responses to PPS and the cost-cutting measures of other payers of hospital bills.

2. The Decline of the Nonprofit Hospital Sector

The repeal of the tax-exemption for nonprofit hospital bonds would have two immediate consequences for hospitals in need of capital.

First, hospitals with insufficient credit standing would be denied access to the taxable bond market. Today the capital needs of many nonprofit hospitals go partially or totally unmet because they lack the financial standing to raise capital in the tax-exempt market. The proposal as submitted would exacerbate this situation and substantially increase the amount of needed capital projects that are not funded. The hospitals least able to raise capital in the taxable market would be the inner-city hospitals and rural hospitals in economically distressed areas and the hospitals that serve large numbers of Medicare, Medicaid, and indigent patients. Often, these institutions are sole providers of medical care to their communities. Their patients and communities would bear the brunt of this proposal.

Second, hospitals with the financial strength to raise capital in the taxable market would face increased debt service costs and decreased liquidity and operating margins. Over time, some of the hospitals initially able to raise capital in the taxable market would no longer be able to do so because of the adverse effects on their financial position caused by the use of more expensive and shorter maturity taxable debt.

For hospitals unable to raise needed capital, the ravages of time and hard usage would take their toll. Facilities would not be modernized, renovated, replaced, or expanded. New equipment would not be purchased. Alternative, less expensive forms of health care delivery would not receive the impetus necessary for their expansion and development. The hospital would become less capable of properly serving its clientele and would lose patients able to pay for service at other hospitals. With each passing year, the cumulative effects of these consequences would increase. Over time, the reduction in paying patients or the inability to meet health and safety codes would eventually cause some nonprofit hospitals to close or be taken over by public hospitals.

This would lead to a structural change in the health care system, with an increased and more overburdened public hospital system and larger proprietary hospital system. We believe that our present mix of a strong and predominant nonprofit sector with public and proprietary sectors would better serve the public interest.

B. Nonprofit Hospitals Serve a Public Purpose

Nonprofit hospitals perform a traditional governmental role and serve the general public by protecting the health of their communities. The President's tax reform proposal would continue the tax-exemption for bonds used to finance public facilities owned by governments or available for use by the general public. The exemption is based on comity between the federal and state governments. Based on these principles, the tax-exemption for nonprofit hospital bonds should be retained.

As discussed above, nonprofit hospitals serve the lion's share of Medicare, Medicaid, and indigent patients. They perform socially desirable but generally unremunerative services far in excess of their proportion of total hospital services. They are created, sponsored, and governed by the communities they serve. Their bonds are issued by state-created authorities directed by persons appointed by their state or local governments. They have section 501(c)(3) tax-exempt status because they have established that they benefit their community, serve a public rather than a private interest, and perform a function that would otherwise be performed by government because of its traditional responsibility for public health.

The National Council believes that these unique characteristics of nonprofit hospitals qualify the bonds, issued on their behalf, for the same treatment as bonds issued on behalf of governmental entities. These facilities truly serve the general public. In addition, the states' interest in and responsibility for public health is so strong that the principle of comity requires the recognition of these bonds by the federal government as eligible for tax-exempt status.

C. The Reasons for the Proposal Do Not Apply to Nonprofit Hospitals

The President's proposal lists several reasons for repealing the tax-exemption for bonds not issued for governmental users. However, these reasons do not apply to nonprofit hospital bonds, or only apply to them in an attenuated fashion.

1. Hospital Bonds Do Not Seriously Erode the Tax Base

As discussed above, tax-exempt bonds for nonprofit hospitals account for only 10 percent of all tax-exempt bonds issued, and this percentage has been steadily decreasing in the last few years. While the amount of hospital bonds issued is not insignificant, it is doubtful that the retention of the tax-exemption for such bonds would constitute a serious erosion of the tax base. This is especially true when one considers the effect of the proposed reduction in marginal tax rates and the "reflow" effects of the additional investment, neither of which is apparently considered in the Treasury's computation of revenue loss from the tax-exemption.

In addition, Congress should consider not only the revenue effect of this proposal but also the expenditure effect. Hospital capital costs are partially reimbursed through the Medicare and Medicaid programs. Any increase in capital cost caused by financing at higher taxable bond rates would be passed on, in part, to the federal government through increased Medicare and Medicaid capital reimbursement payments. If the federal government reduced such reimbursement, this would be an inequitable double blow to nonprofit hospitals.

2. Hospital Bonds Are Not an Unscrutinized Tax Expenditure

Hospital bond issues are carefully scrutinized by both state and federal governments. Hospital capital improvements are generally subject to careful review under the certificate-of-need (CON) review process. Most states require CON review for all capital improvements and major equipment purchases. Participation in the FHA section 242 credit enhancement program requires a federally recognized CON. In addition, section 1122 of the Social Security Act requires that necessary planning approvals be secured as a condition of receiving depreciation and interest expenses under Medicare.

3. State and Local Governments Spend Their Own Funds on Hospitals

Public health is a basic and traditional responsibility of state and local governments. State and local governments today spend substantial amounts of their own funds on public health care facilities. It is clear that in the absence of nonprofit hospitals, state and local governments would have to spend more of their own funds for facilities to serve many of the patients now served by nonprofit hospitals.

Another element of the President's tax reform proposal would repeal the exemption for state and local taxes. This proposal would make it more difficult for states and municipalities to raise taxes in order to expand public hospitals to service patients driven from undercapitalized nonprofit hospitals or to acquire failing nonprofit hospitals.

4. A More Efficient Subsidy for Hospitals' Capital Needs Is Not in Existence

The President is not proposing to replace tax-exempt hospital bonds with a more efficient form of subsidy. Clearly, there will be no new grant program to replace the tax-exemption for hospital bonds in order to provide for the capital needs of nonprofit hospitals. Even assuming that this subsidy mechanism is less efficient than the federal bureaucracy, and that it would be consistent with our federal system to inject the federal government into the properly local decision of determining what hospital capital needs would be met, the choice is not between a more or less efficient subsidy, but rather between a needed subsidy and no subsidy.

5. Hospital Bonds Are Not Anticompetitive

The availability of tax-exempt hospital bonds for nonprofit hospitals is needed to avoid the anticompetitive effect due to the advantages enjoyed by both public and proprietary hospitals over nonprofit hospitals in their ability to raise and pay for capital. The public hospitals have access to tax revenues to meet their capital needs. The proprietary hospitals have access to equity capital, receive depreciation and investment credit tax benefits, and get reimbursement for their return-on-equity. The tax-exemption for hospital bonds is an important way nonprofit hospitals can compete for capital with the public and proprietary hospital sectors.

6. Hospital Bonds Do Not Act to the Detriment of State and Local Government Financing

As discussed above, long-term deterioration of nonprofit hospitals caused by the the denial of access to the capital markets would shift patients to public hospitals. This would increase the need for state and local government bonds to finance expanded or additional public hospitals facilities. The repeal of the tax-exemption for nonprofit hospital bonds would be to the detriment of state and local government financing in such circumstances.

IV. Conclusion

The National Council of Health Facilities Finance Authorities believe that Congress should retain the tax-exemption for nonprofit hospital bonds. This tax-exemption is amply justified on health policy grounds and its repeal is not justified on tax policy grounds. In considering this proposal, Congress should view the harm to the nonprofit sector and the entire health care system in light not only of the proposed repeal of this tax-exemption, but also in light of proposed changes in the taxation of charitable contributions and in federal credit enhancement programs and reimbursement policies.

The nonprofit hospital sector, an essential element of the world's best health care system, should not be impaired without a compelling reason. This component of the President's tax reform proposal does not provide such a reason.

Footnotes

1/ See American Hospital Association Hospital Statistics, 7 (1984 ed.)

2/ See Id. at 193-198.

3/ See Modern Healthcare, 11, July 5, 1985 (reporting on survey by Lewin & Associates and Johns Hopkins School of Public Health to be released later this year).

4/ Medicare and Medicaid data prepared by ICF Incorporated; uncompensated care data from What Legislators Need to Know About Uncompensated Health Care, National Conference of State Legislatures, Foundation for State Legislatures.

5/ Credit Markets.

6/ Preliminary data prepared by Amherst Associates Inc. for a study to be issued by the Healthcare Financing Study Group.

7/ Independent Sector, Questions and Answers Regarding the Impact of the President's Tax Plan on Charitable Giving.

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LEGISLATIVE INFORMATION

STATEMENT OF
THE NATIONAL EDUCATION ASSOCIATION
ON MANDATORY COVERAGE OF PUBLIC EMPLOYEES
UNDER MEDICARE AND SOCIAL SECURITY
BEFORE THE
COMMITTEE ON FINANCE
OF THE
UNITED STATES SENATE
SEPTEMBER 11, 1985

MARY HATWOOD FUTRELL, President • KEITH GEIGER, Vice President • ROXANNE E. BRADSHAW, Secretary-Treasurer
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This statement presents the views of the National Education Association, representing 1.7 million teachers, education support personnel, and higher education faculty in every state in the Union. NEA urges this Committee to reject any proposal to force Medicare and/or Social Security coverage on public employees who are not presently covered. The policy of the Association in this matter is in its Legislative Program, adopted by the more than 7,000 delegates to the annual Representative Assembly.

Why NEA Members Oppose Mandatory Coverage

When Congress created the Social Security system, our members and other public employees were excluded from participation in it. Indeed, it was more than twenty years after enactment that the opportunity for state and local public employees to choose whether they wished to attain coverage was afforded by law.

Public education employees excluded from Social Security worked at the state and local level to fashion retirement systems that would afford benefits equal to or better than those provided by Social Security. This has largely been accomplished at great expense to state and local governments as well as to the employees themselves. Extensive state law has developed to assure that the benefits of public education retirement systems will be adequate and predictable far into the future.

Today, more than 600,000 of NEA members concentrated in 14 states work in jobs not covered by Social Security (see Charts 1 and 2 in the appendix to this statement). On behalf of these members, the entire NEA strongly opposes any initiative to force them into the Social Security system. The last major study on the issue conducted by the Department of Health, Education, and

Welfare concluded that the disruption of state and local government fiscal operations would be severe, especially in states that operate their retirement plans on a pay-as-you-go basis. It also noted the complexity of administrative detail that would be required at the state and local level to comply with mandatory coverage.

After many months of hearings, the 1982/83 National Commission on Social Security Reform concluded that the coverage of state and local employees was not feasible, and Congress did not include such coverage in the financing reform package it adopted in March, 1983. Until the single day of hearings by this Committee, no further consideration of coverage has been undertaken by Congress. It is clearly inappropriate for the federal government to mandate such a major change affecting existing state and local laws and budgets without a full and complete hearing process.

Mandatory Coverage Will Impede Educational Reform

The extension of coverage will disrupt state and local government finance with no warning. These governments are already facing the primary impact of the Garcia v. San Antonio Metropolitan Transit Authority ruling -- payment of overtime to police and firefighters. The federal share of education expenditures is at its lowest point in twenty years. And states and localities are pressed by the threat of losing the deductibility of state and local taxes.

For those concerned with public education, the extension of coverage would add new costs for retirement at the exact time that state and local governments are trying to implement meaningful educational reform. States all across America have committed resources to the nationwide effort to improve the quality of instruction and raise teacher salaries at all levels of education. It has been estimated that the cost of implementing the recommendations of the National Commission on Excellence in Education alone would be $14 billion -- representing an 11 percent increase in operating expenses for state and local school systems.

There are no unused resources which can be committed to mandatory coverage. Educational reform, increased numbers of children in the schools, the necessity of more teachers and classrooms, and the unmet needs of many children are creating immense financial pressures. The federal government is not doing its fair share -- and it should not throw up additional obstacles to improving education. To cite just one glaring example: less than half of the children eligible for Chapter 1 services for the disadvantaged are receiving those services due to inflation and Administration cuts.

Our conservative estimate is that state and local governments would have to come up with at least $437 million in new revenues to cover all noncovered school employees just under Medicare in the first year alone. The employees themselves would have to pay a like amount, deducted from their paychecks. The cost of covering all school employees under Social Security would be a staggering $2.1 billion in the first year. Again, employees themselves would pick up a like amount, deducted from their paychecks. In the noncovered states, employers now contribute between eight percent and 17.4 percent of total payroll to their retirement plans. California, laboring under severe property tax limitations, contributes $574 million to its retirement plan annually, but under mandatory Medicare coverage it would would need to raise another $104 million in the first year alone. The current employer contribution and the estimated costs of mandatory Medicare and Social Security coverage of school employees in the noncovered states are shown in Charts 3 and 4 of the appendix to this statement. The estimates in the charts are based on the current employer contribution plus the additional payroll tax times the state average teacher salaries. In addition to the 14 states listed, the following have substantial numbers of noncovered school employees: Georgia; Montana; New Mexico; North Dakota; Oklahoma; and Vermont.

A Further Disincentive to Teaching

NEA is concerned about our need to attract and retain high quality teachers. The average entry level salary for teachers is less than $15,000, and adequate, affordable retirement benefits are an important incentive to enter and remain in the teaching profession. Teachers are already contributing seven to 9.5 percent of their salary to retirement. Imposing the additional tax burden of Medicare and/or Social Security would be untenable. In Illinois, for example, the average teacher who makes $23,347 would pay $3607 for retirement.

A Breach of Faith

Planning for retirement is a far more complex and time-consuming process than planning the purchase of a car or a home. Decades of planning, implementation, and funding have gone into the retirement systems in the noncovered states. Contribution and benefit systems are in place and are stabilized.

Public employees will view the imposition of coverage as a breach of faith. Their own expensive contributions to retirement plans were made with the clear and certain knowledge that they were building a solid foundation for their own future. It is inconsistent to change the rules in mid-stream.

Extending coverage to these employees by legislative fiat subjects them to a tax they could never have anticipated. The retirement plans themselves would certainly be subject to review and to changes that invite less in pension benefits.

Social Security Doesn't Need the Money

The proposals to extend Medicare and Social Security coverage to state and local employees have been made in the context of reducing the federal deficit. Specifically, the budget resolution for Fiscal 1986 appears to assume an approximately $8 billion yield from the coverage of all state and local employees under Medicare and all new hires under Social Security. The coverage of new hires only, under either Medicare or Social Security, would yield relatively little money, but would seriously erode the fiscal integrity of state and local retirement systems in the long run.

The fact is that the Social Security system is running a surplus that is estimated to reach $60 billion by 1990, and under current law the system will be pulled out of the unified federal budget two years after that. Current projections show the system operating well in the black through the first quarter of the 21st century. Given these facts, we must view the proposals to extend coverage as cynical budget manipulation. In 1983, Congress protected present and future Social Security beneficiaries against the political and economic winds that had buffeted the system, and it is only reasonable to ask that Congress now avoid any action that would penalize those who are not covered by it.

The evidence is equally clear that the Medicare Hospital Insurance Trust Fund doesn't need a bail-out. According to the 1985 report of the Social

Security Board of Trustees, the trust fund is in good shape through the end of this century, and the rate of medical care cost inflation has dropped substantially over the past two years. Imposing the Hospital Insurance payroll tax on state and local employees is inappropriate because the system doesn't need the money, and it is wrong to force Medicare coverage on employees who have made alternative plans for their health care insurance.

The extension of either Medicare or Social Security coverage to state and local employees adds an additional burden of making massive, unwarranted, and unwanted changes in the health and retirement legislation in every state where employees are not now covered, with little time to make those changes. In the two years since the mandated coverage of newly-hired federal employees Congress has yet to enact legislation to meet the retirement needs of those employees. It is grossly unfair to expect states to meet that kind of challenge in a shorter time period.

We urge the Committee to reject any proposal that would mandate Medicare or Social Security coverage for state and local employees.

Thank you.

Chart 1

TABLE 1.–SOCIAL SECURITY COVERAGE OF PUBLIC SCHOOL TEACHERS

37 State Retirement Systems

State 1	Effective date of coverage 2	Type of coverage 3
Alabama	1955	Supplementary; statewide
Arizona	1953	Supplementary; statewide
Arkansas	1961	Coordinated; statewide
Delaware	1953	Supplementary; statewide
Florida[a]	1970	Supplementary; statewide
Georgia	1956	Supplementary; local option; limited application
Hawaii	1956	Supplementary; divisional; limited application
Idaho	1956	Supplementary; statewide
Indiana	1955	Coordinated; statewide
Iowa	1951	Supplementary; statewide
Kansas	1955	Supplementary; statewide
Maryland	1956	Supplementary; statewide
Michigan	1955	Coordinated; statewide
Minnesota	1960	Coordinated; limited application
Mississippi	1951	Coordinated; statewide
Montana	1955	Supplementary; local option; limited application
Nebraska	1955	Supplementary; statewide
New Hampshire	1957	Coordinated; statewide
New Jersey	1955	Supplementary; statewide
New Mexico	1955-56	Supplementary; local option; limited application
New York	1958	Supplementary; divisional; limited application
North Carolina	1955	Coordinated; statewide
North Dakota	1955	Supplementary; local option; limited application
Oklahoma	1955-56	Supplementary; local option; limited application
Oregon	1951	Coordinated; statewide
Pennsylvania	1956	Supplementary or offset; divisional; limited application
South Carolina	1955	Coordinated; statewide
South Dakota	1951	Supplementary; statewide
Tennessee	1956	Coordinated; divisional; limited application
Texas	1956	Supplementary; local option; limited application
Utah	1953	Supplementary; statewide
Vermont	1963	Supplementary; local option; limited application
Virginia	1951	Coordinated; statewide
Washington	1957	Supplementary; statewide
West Virginia	1956	Supplementary; statewide
Wisconsin	1955	Coordinated; divisional; limited application
Wyoming	1951	Supplementary; statewide

[a] Established in 1970 to include all public employees; provides mandatory Social Security coverage for members. Teachers who chose to remain in the former teachers' retirement system are not covered by Social Security.

Chart 2

TABLE 2.–SOCIAL SECURITY COVERAGE OF PUBLIC SCHOOL TEACHERS

Eight Local Retirement Systems

Full supplementation: No modification of existing retirement system 1	*Coordination:* Existing retirement system modified to adjust to OASDHI 2	*Divisional:* Basis offset 3
Des Moines, Iowa, 1953	Kansas City, Missouri, 1955[a]	Knoxville, Tennessee, 1963
Duluth, Minnesota, 1957	Omaha, Nebraska, 1955	
	New York, New York, 1956[a]	Milwaukee, Wisconsin, 1955[b]
	Portland, Oregon, 1955	

[a] Fully supplemental and coordinated types of coverage are provided.

[b] Offset for service before September 1, 1958, retroactive to January 1, 1955; supplemental for service after September 1, 1958.

TABLE 3.–TEACHER RETIREMENT SYSTEMS THAT DO NOT HAVE SOCIAL SECURITY COVERAGE

13 State, 4 Local

State system 1	Local system 2
Alaska[a]	Denver, Colorado
California[a]	Chicago, Illinois
Colorado	Minneapolis, Minnesota[b]
Connecticut[a]	St. Paul, Minnesota[b]
Illinois	
Kentucky	
Louisiana	
Maine	
Massachusetts[a]	
Missouri	
Nevada[a]	
Ohio	
Rhode Island[a]	

[a] Authorized by amendments to the Social Security Act to adopt OASDHI on a divisional basis, but have not done so.

[b] Minnesota has coordinated Social Security coverage on a divisional basis; but no coverage is provided in Minneapolis and St. Paul.

Chart 3

COST OF MEDICARE COVERAGE ALL PUBLIC EMPLOYEES

State	Membership in System	Av. Salary	Benefit Formula	Employee Contrib.	Employer Contrib.	Employer Dollar Contribution	Employer Contrib. w/Medicare Added	Added Cost to Employers
Alaska	7822	$34,510.00	2.00%	7.00%	17.42%	$47,023,063.72	$50,937,153.41	$3,914,089.69
California	260362	$27,553.00	2.00%	8.00%	8.00%	$573,900,334.88	$677,919,770.58	$104,019,435.70
Colorado (P)	51289	$22,291.00	2.00%	8.00%	12.60%	$144,053,670.47	$160,631,275.41	$16,577,604.94
Connecticut	40108	$21,770.00	2.00%	6.00%	NA	$96,800,000.00	$109,460,691.82	$12,660,691.82
Illinois	101741	$23,347.00	2.00%	8.00%	NA	$169,000,000.00	$203,442,533.34	$34,442,533.34
Kentucky	43426	$19,230.00	2.00%	7.84%	11.09%	$92,610,591.58	$104,719,280.29	$12,108,688.71
Louisiana	79679	$19,749.00	2.50%	7.00%	9.30%	$146,342,993.10	$169,159,911.38	$22,816,918.28
Maine (P)	17469	$16,205.00	2.00%	6.50%	16.00%	$45,293,623.20	$49,398,357.80	$4,104,734.60
Massachusetts	70000	$23,000.00	2.50%	7.00%	NA	NA	$23,345,000.00	$23,345,000.00
Missouri (S)	54627	$18,216.00	2.00%	9.50%	9.50%	$94,533,116.04	$108,961,854.80	$14,428,738.76
Nevada (P)	41407	$26,412.00	2.00%	8.00%	16.00%	$174,982,669.44	$190,840,473.86	$15,857,804.42
Ohio	165871	$20,730.00	2.00%	8.50%	13.50%	$464,198,287.05	$514,056,621.59	$49,858,334.54
Rhode Island (P)	23600	$23,600.00	2.00%	6.50%	10.80%	$60,151,680.00	$68,227,600.00	$8,075,920.00
Texas (S)	395578	$20,092.00	2.00%	6.50%	8.50%	$675,576,019.96	$790,821,341.01	$115,245,321.05

LEGEND

Total added cost, first year...... $437,455,815.85

P: Includes all public employees,
of which an average of 60% are teachers

S: Includes all school employees

Note: California employer contribution of 8 percent
is supplemented by a state appropriation, not included

Source: NEA Retirement Survey, 1984
Added costs computed by NEA Government Relations

Chart 4

COST OF SOCIAL SECURITY COVERAGE ALL PUBLIC EMPLOYEES

State	Membership in System	Av. Salary	Benefit Formula	Employee Contrib.	Employer Contrib.	Employer Dollar Contribution	Employer Contrib. w/Soc.Sec. Added	Added Cost to Employers under SS
Alaska	7822	$34,510.00	2.00%	7.00%	17.42%	$47,023,063.72	$65,918,669.12	$18,895,605.40
California	260362	$27,553.00	2.00%	8.00%	8.00%	$573,900,334.88	$1,076,063,127.90	$502,162,793.02
Colorado (P)	51289	$22,291.00	2.00%	8.00%	12.60%	$144,053,670.47	$224,083,487.40	$80,029,816.93
Connecticut	40108	$21,770.00	2.00%	6.00%	NA	$96,800,000.00	$177,401,458.48	$80,601,458.48
Illinois	101741	$23,347.00	2.00%	8.00%	NA	$169,000,000.00	$230,557,156.78	$61,557,156.78
Kentucky	43426	$19,230.00	2.00%	7.84%	11.09%	$92,610,591.58	$151,066,330.18	$58,455,738.60
Louisiana	79679	$19,749.00	2.50%	7.00%	9.30%	$146,342,993.10	$256,493,633.07	$110,150,639.97
Maine (P)	17469	$16,205.00	2.00%	6.50%	16.00%	$45,293,623.20	$65,109,583.35	$19,815,960.15
Massachusetts	70000	$23,000.00	2.50%	7.00%	NA	NA	NA	$113,505,000.00
Missouri (S)	54627	$18,216.00	2.00%	9.50%	9.50%	$94,533,116.04	$164,189,096.28	$69,655,980.24
Nevada (P)	41407	$26,412.00	2.00%	8.00%	16.00%	$174,982,669.44	$251,537,587.32	$76,554,917.88
Ohio	165871	$20,730.00	2.00%	8.50%	13.50%	$464,198,287.05	$704,893,695.15	$240,695,408.10
Rhode Island (P)	23600	$23,600.00	2.00%	6.50%	10.80%	$60,151,680.00	$99,138,880.00	$38,987,200.00
Texas (S)	395578	$20,092.00	2.00%	6.50%	8.50%	$675,576,019.96	$1,231,932,742.28	$556,356,722.32

LEGEND

Total cost, first year........ $2,027,424,397.87

P: Includes all public employees,
of which an average of 60% are teachers

S: Includes all school employees

Note: California employer contribution of 8 percent
is supplemented by a state appropriation, not included

Source: NEA Retirement Survey, 1984
Added costs computed by NEA Government Relations

Statement on

Proposed Increases in the Black Lung Excise Tax

by

James Scahill
Executive Vice President
PENNSYLVANIA COAL MINING ASSOCIATION (PCMA)

on behalf of the

MINING AND RECLAMATION COUNCIL OF AMERICA (MARC)

before the

Finance Committee
United States Senate

September 13, 1985

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Mr. Chairman, members of the Finance Committee. I am James Scahill, Executive Vice President, of the Pennsylvania Coal Mining Association (PCMA) and appear today on behalf of the Mining and Reclamation Council of America (MARC) and PCMA to request that the Finance Committee and the full Senate oppose the increase in the black lung excise tax approved by the Ways and Means Committee of the House of Representatives as a part of H.R. 3128, the Deficit Reduction Act.

MARC is a national association of coal producers and ancilliary industries whose members and affiliated state and regional coal associations produced over 60 percent of the nation's coal production this past year. PCMA is a state association of surface coal producers whose members accounted for 75 percent of the surface coal production in Pennsylvania in 1984.

In the time available, I will briefly address the reasons why MARC and PCMA are strongly opposed to the inclusion of an increase in the black lung excise tax in the omnibus reconciliation bill for 1986. I encourage committee members to review MARC's full statement submitted for the record and the separate statement submitted on behalf of PCMA.

PERSPECTIVE

In 1969, the Congress, in response to a large number of coal miners suffering from black lung disease, established a federal worker's compensation program for miners disabled by black lung. The program was in addition to worker's compensation programs available at the state level, and supplemented social security disability. Unlike traditional worker's compensation programs, the benefits provisions extended through the life of the miner, his widow and children through maturity.

In 1972, the Congress imposed future liability for claims directly on coal operators and in 1977, as a result of claims being denied when individuals could not establish they were suffering from black lung, the Congress decided to basically establish what some have characterized as an entitlement program for former coal miners and to impose the liability for that program on the coal industry. Nearly 100,000 claims were approved under the 1977 Amendments which extensively liberalized eligibility criteria and established the Fund with a tax of $.50/ton on underground coal and $.25/ton on surface mined coal.

In that legislation the Congress arbitrarily levied a tax on all coal produced in spite of the fact that studies showed that black lung is not contracted by working at surface mines[1] and imposed the financial burden on the coal industry in the future in spite of the fact that dust control measures required since 1969 significantly reduced the possibility of contracting black lung disease in coal mining.

No other industry in the United States is subject to such a program or such taxes. Now the Administration and the Ways and Means Committee are proposing to further perpetrate this arbitrary determination by simply increasing taxes, irrespective of the impact on the coal industry and its customers -- consumers of electricity.

The Congress must not simply pass a tax increase and "sweep the problem under the rug" until the next crisis arises. The Congress, through two sets of amendments in the 1970's created the problem, and it has a responsibility to review the entire program's problems through the normal legislative process.

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[1] Coverage for the Act was also expanded in the 1972 amendments to surface mines, even though the Congressional hearings revealed no evidence that the incidence of pneumoconiosis was significant among surface miners. A later study of 1438 Eastern surface miners by the U.S. Public Health Service showed that only 59 (4%) had roentgenographic evidence of pneumoconiosis, and of those 59, only seven had degrees of simple beyond the first stage. These seven had an average term of 17 years of surface mining preceded by an average of 14 years' underground work. Of the 1171 surface miners who had never worked underground, only 2.5% showed X-ray evidence of pneumoconiosis.

As with efforts to address the federal deficit, the Congress, and hopefully the Administration should first explore alternatives to reducing the cost of the program -- to evaluate:

- 0 who should pay for the program;
- 0 whether it should be made a true worker's compensation program;
- 0 whether black lung beneficiaries should only receive social security benefits following retirement as other Americans;
- 0 whether abuse or fraud exists in the various components of the program;
- 0 whether the claimants approved between 1977 and 1981 under the vastly liberalized criteria are actually disabled by black lung disease;
- 0 and, whetner the program is efficiently managed, especially the rapidly escalating cost of medical treatment.

If the coal industry is to be further saddled with another tax increase, these questions, in addition to others, must be scrutinized. If they aren't, this additional burden, along with other government imposed costs, will result in a substantially reduced domestic coal industry to tax. This would further exacerbate the funding problems of the black lung program as well as other Federal and state programs directly dependent on taxes on coal.

MARC believes the Congress must address these questions and evaluate additional options for addressing the Fund's deficit prior to enacting yet another tax increase. The potential impact of changes on the program's beneficiaries; future domestic production and employment in the coal industry; and regional and international industry restructuring that will result from an increase need to be assessed.

In assessing the financial condition of the Fund, the Committee should recognize that the primary financial drain on the Fund which impedes it from attaining solvency is the interest expense on the debt which has averaged 11.5% since the 1981 tax increase. Of the $874 million expended by the Fund in 1984, $271 million -- approximately one-third of the outflow went for interest and administrative expense. It should be noted that the projected receipts of the Fund in 1985, $584 million, nearly equals the projected benefit and medical payments of $632 million. Increasingly, the coal industry is being asked to pay the interest on a debt it was not responsible for creating and over which it had no control.

BACKGROUND

In its budget proposal for FY85, the Administration indicated that it would seek an increase in the current black lung excise tax.

Subsequently, on meetings with industry and labor, the Labor Department outlined a proposed tax increase and a freeze on benefit levels for FY86 and FY87. No legislative proposal to authorize an increase has been submitted to the Congress to date.

In spite of this and the fact that neither the House nor Senate Budget Resolution presumed an increase in the tax, the House Ways and Means Committee in closed session in late July, approved a 50 percent increase in the tax. The Ways and Means Committee did not include the benefit level freeze relied upon by the Labor Department in its projections.

As the Committee is aware, the black lung excise tax was imposed in 1977 to: (1) fund a benefit program for miners suffering from black lung disease and their dependents and survivors when the miners last coal mine employment was prior to January 1, 1970 or when a last responsible coal mine employer could not be identified, and (2) to pay the medical expenses related to black lung disease of such individuals.

The tax is assessed on all coal produced in the United States, except lignite, and was established at a level of $.50/ton on underground mined coal. land and $.25/ton on surface mined coal with a cap of 4 percent of the sales price of the coal. The 1977 Amendments also substantially liberalized the eligibility criteria for black lung benefits and directed that all previously denied claims be reviewed under the liberalized criteria. Approximately 45 percent, 56,957 claims were approved under the liberalized eligibility criteria established by the 1977 Amendments for review of previously denied claims. This compares to an average approval rate of 7 percent under the administration of other formulations of the program in other years. It should also be noted that all administrative costs of the program: case processing, judicial review, and medical examination costs are paid by the Fund.

Although the 1977 tax was projected to meet the future obligations of the Fund, as a result of the high approval rate for benefit claims, revenue of the Fund proved to be inadequate to meet its obligations. As a consequence, it was necessary for the Fund to borrow from the Treasury to meet its obligations.

By 1980 the Fund had a $1.5 billion debt to the Treasury and it was apparent that the existing tax was insufficient to fund the program. In 1981 the Congress doubled the black lung tax to $1.00/ton on underground coal and $.50/ton on surface coal, eliminated several presumptions in the Act and revised the evidentiary standards. The doubling of the tax was an interim increase which was scheduled to revert to its initial level by 1995 or sooner when the Fund became solvent. The 1981 tax increase was projected to meet the obligations of the Fund and repay the Treasury advances with interest prior to 1995. Both the 1977 tax and the 1981 tax were imposed on the coal industry irrespective of the fact that a substantial number of the coal companies which pay the tax were not in existence prior to 1970 and did not employ the individuals found eligible for benefits from the Fund.

The Labor Department is now stating that its projections in 1981 were wrong and that over the past four years, rather than decreasing, the debt to the Treasury Department has grown to $2.5 billion dollars. In order to address this deficit, the Department has proposed to enact yet another increase in the tax. The coal industry considers this approach to be wholly inequitable and unacceptable. It will continue to penalize companies which were not responsible for the conditions which led to the program's beneficiaries contracting black lung disease; impose yet another tax on a depressed industry[2/] which is already subject to several industry specific federal and state taxes[3/]; place American coal producers at a yet greater disadvantage in competing with foreign producers in both domestic and international markets; and result in reduced employment and income in the coalfields of the United States.

[2/] The number of coal mines in the United States has declined from over 7,000 in 1977 to approximately 3,000 in 1984.

[3/] In addition to the federal black lung tax, coal operators also must pay a federal surface mining fee of $.35/ton on surface coal and $.15/ton on underground coal; state severance taxes per ton that range to as high as 30 percent; 12% and 8% royalties respectively on surface and underground coal mined on federal lands; and separate black lung and surface mining. taxes in several states -- in addition to federal and state income taxes; workers compensation, social security, and business taxes. Federal and state taxes and fees, directly on coal, (exclusive of income taxes), range from approximately 12% to as high as 40% of the FOB mine price of the coal.

The Department of Labor has outlined the current deficit of the Fund and proposed a tax increase to address it. On December 14, 1981, approximately one week before the Congress approved a doubling of the tax increase, the Department, in testimony before the Labor Subcommittee in the Senate testified:

> The Administration proposed to raise the existing tonnage tax rates to $1.00 per ton for underground-mined coal and $.50 per ton for surface-mined coal, or 4 percent of the sales price, whichever is less. The new tax rates would revert to current levels at the end of Calendar Year 1995, or sooner if the current debt is retired prior to that date. This tax rate, coupled with the changes proposed in evidentiary and eligibility standards, would eliminate the need for repayable advances from the Treasury after FY85, and allow full repayment to the Treasury of accumulated principal and interest by FY94.

Now, less than four years later, the coal industry is facing yet another tax increase to accomplish what was promised by the tax increase in 1981. In fairness to the Department, it did qualify its projection of solvency and repayment of the $1.5 billion debt which existed at that time by the accuracy of projections on coal production and interest rates. The point, however, is that the Congress should not simply raise taxes to fund the problem. It must analyze the problem and explore alternative solutions. At risk is the continued viability of a substantial segment of what is currently a highly competitive coal industry and the benefits that accrue to other industries and citizens as consumers of electric power as a result of a competitive industry.

According to the Energy Information Agency, small companies have suffered a dramatic decline in nationwide production share in recent years. Between 1977 and 1983, companies producing less than 200,000 tons realized an overall production share decline of 35%. Producers in the 200,000 to 500,000 ton range lost nearly 9% of production share, while companies mining 500,000 tons and up realized a 45.3% increase in their percentage of overall production. Ten years ago there were over 7,000 coal producing companies in the U.S. -- today there are approximately 3,000. There is every reason to believe this trend will continue. With today's continuing tight coalmarket and depressed prices, even more small producers will be pushed out of the market.

The black lung tax and the responsible operator provisions of the Act are not the exclusive force behind this dramatic restructuring of the coal industry. They are, however, a significant contributing factor.

The appealing and simple solution to the existing problem would be to project the deficit of the Fund, pick a year in which solvency would be desirable, and then calculate the necessary black lung tax increase to fulfill that objective. Proponents of such a solution will argue that the coal companies can simply pass this cost along to their customers. This line of reasoning is dangerous. It ignores the realities of the competitive market for coal. The majority of the coal operators will have to absorb any increased tax. The price of coal is set by the economic law of supply and demand, including imports, not the cost of production taxes, and fees.

In the domestic coal market, almost all sales by the remaining smaller producers are made in the highly competitive spot market where the sale is awarded to the low bidder. While competitive bidding is also the norm for long-term contracts, unanticipated cost increases as a change in tax laws, are sometimes provided for in the final contract. Many new utility contracts provide for passing through increased taxes. However, many older contracts do not. In the once promising export market for coal, both steam and metalurgical, contracts generally do not provide for a pass through of increased taxes. Insistence on such a provision often precludes a producer from consideration by prospective buyers.

While the ability to pay the tax should not be determinative, the committee should be aware that the estimated before tax income of the nation's independent coal producers for 1984 was less than $1 billion dollars. This Department of Commerce figure should be viewed in comparison with the estimated annual impact of a 50% increase in the existing tax which is approximately $250 million. Obviously, any tax increase will have a significant impact on the number of coal operators who remain in business.

CONCLUSION

In conclusion, Mr.Chairman, before the Congress considers simply raising the tax to repay the Fund's deficit, it should thoroughly examine the black lung program and re-evaluate the arbitrary policy determinations made earlier to impose the total cost of the program on operators who did not contribute to the problem and are now being asked to share even a greater burden.

WRITTEN STATEMENT

by

THE BOARD OF TRUSTEES

of

THE PUBLIC SCHOOL TEACHERS' PENSION AND RETIREMENT FUND OF CHICAGO

for the hearing record on

EXTENDING SOCIAL SECURITY OR MEDICARE TO STATE AND LOCAL GOVERNMENT EMPLOYEES

September 11, 1985 Senate Finance Committee	219 Dirksen Senate Office Building

INTRODUCTION:

The following statement is made on behalf of the Public School Teachers' Pension and Retirement Fund of Chicago, a state/local government retirement system which provides retirement, disability, and survivor benefits for approximately 37,000 active and retired Chicago public school teachers. It is the belief of the Board of Trustees of this Fund that current proposals to mandate Medicare for all public employees and to mandate Social Security for all newly-hired public employees would be ill-advised and counter-productive. These proposals would generate spiraling increases in the long-term actuarial liability faced by the Social Security system, rather than provide a continuing source of new revenue. Further, these changes would undermine the stability of the long-established public employee retirement systems to which state and local public employees have contributed and upon which they rely for their total retirement security, not the supplemental benefits provided by the Social Security programs. The Public School Teachers' Pension and Retirement Fund of Chicago has been providing continual, comprehensive benefits for members since its creation in 1895.

The purpose of this testimony is to elaborate on the many reasons that the extension of Social Security in any form to state or local public employees would be an unsound and discriminatory fiscal policy decision. We encourage members of the Senate Finance Committee to consider alternative sources of revenue -- alternatives which would generate needed revenues without increasing the federal government's entitlement obligations while simultaneously imposing a tax burden on state and local governments and their employees.

Name and address of spokesman:

Robert T. Wilkie, President
Board of Trustees
Public School Teachers' Pension and Retirement Fund of Chicago
205 West Wacker Drive, Room 820
Chicago, Illinois 60606
Telephone: (312) 641-4464

A STATEMENT FOR THE WRITTEN RECORD IN OPPOSITION TO MANDATORY MEDICARE OR MANDATORY SOCIAL SECURITY FOR STATE OR LOCAL PUBLIC EMPLOYEES

In recent weeks, both the House of Representatives and the Senate have considered legislation to extend Social Security programs to state and local public employees in order to generate new "savings" in the form of new contribution revenues. Senate Congressional Resolution 32 includes a mandate to the Senate Committee on Finance to raise $8.4 billion in revenues in fiscal years 1986-1988. Members of both the House of Representatives and the Senate have recommended proposals which they suggest will raise that amount by subjecting all employees of state and local governments to the Medicare (HI) program or by requiring all newly hired employees of those governments to participate in the Old Age, Survivors, and Disability Program (OASDI), effective January 1, 1986.

Since the Social Security system was created in the early 1930's, the trustees of the Public School Teachers' Pension and Retirement Fund of Chicago have continually evaluated the merits of the incorporation of its members into the Social Security system. The conclusion that they have repeatedly drawn is that the disadvantages of the inclusion of Chicago public school teachers in the Social Security system far outweigh the advantages, for public employees themselves, for their state and local governmental employers, and for the country as a whole. As fiduciaries, the Trustees concerns range from the fiscal burdens that would be imposed on the Fund's members, on the educational system in Chicago, and on state and local taxpayers to the impact on the fiscal stability of the teachers' own pension fund and it's ability to meet future benefit obligations. Equally concerning is the infringement on the long-respected doctrine of state's rights. These concerns have been expressed to President Reagan, to members of the Illinois Federal Congressional Delegation, to members of the House Ways and Means Committee, and the Senate/House Budget Confrerees. (See Appendix 1 for copy of recent correspondence to President Reagan.)

Members of the teaching force of the Chicago Public School System are part of the 5 million employees nationwide (approximately 30% of the workforce of state and local government employees) who have not elected to join the Social Security system. Chicago public school teachers are covered by and pay for their own retirement plan, one of the oldest and soundest plans in the nation. The retirement plan provided by the Public School Teachers' Pension and Retirement Fund of Chicago is structured to meet the total retirement needs of teachers, not to provide the supplemental "safety-net" benefits for which Social Security was created.

In August, 1985, the Board of Trustees unanimously passed the latest in a series of resolutions in opposition to any form of mandatory Social Security coverage. It is the policy of the Trustees of this Fund to ratify resolutions only on issues deemed to be of the most critical nature. Two prior resolution, as ratified by the Board of Trustees, are included in Appendix 2. The most recent resolution expresses the Trustees' strong concerns on this matter, as follows.

A RESOLUTION
REGARDING
MANDATORY MEDICARE COVERAGE

WHEREAS, in February, 1983, The Board of Trustees of the Public School Teachers' Pension and Retirement Fund of Chicago ratified a resolution in opposition to the extension of Social Security in any form to state and local government employees, because:

* the enactment of such proposals would create an inequity among employees;

* the enactment of such proposals would create a financial burden on state and local governments and the taxpayers supporting those governmental units;

* serious questions remain regarding the Constitutionality of such proposals as they relate to state sovereignty; and

* the enactment of such proposals guarantees no implicit benefit to newly-covered members and yet serves as a force to undermine the stability and funding of current state and local public employee retirement systems upon which members depend for financial security; and

WHEREAS, since the creation of Social Security in the 1930's, it has been an accepted public policy to exclude state and local public employees from Social Security programs, in deference to the long-standing and improved governmental plans available to public employees via their own retirement systems; and

WHEREAS, in 1983, after considerable study, Congress determined not to extend coverage to state and local government employees excluded from the Social Security system and Medicare program, recognizing that mandatory inclusion of such employees would significantly increase the unfunded liability of the Social Security program in years to come; and

IN VIEW OF recent action by the House Ways and Means Commitee and Joint Budget Resolution adopted by the United States Congress recommending that Medicare contributions be required of all newly-hired state and local government employees (and their employers) effective January 1, 1986, as an attempt to alleviate current fiscal difficulties now faced by the Social Security Administration;

THEREFORE, IN THE INTERESTS OF 27,000 CONTRIBUTORS AND 9,700 ANNUITANTS OF THE PUBLIC SCHOOL TEACHERS' PENSION AND RETIREMENT FUND OF CHICAGO, AND THEIR FAMILIES, BE IT RESOLVED THAT the Board of Trustees of the Public School Teachers' Pension and Retirement Fund of Chicago hereby reiterates and reaffirms its position in opposition to Mandatory Medicare contributions by state or local employees and directs that this resolution be conveyed to all members of the Illinois Federal Congressional Delegation and all other interested parties.

This resolution was the result of serious deliberation and in-depth study of the impact that current proposals would have on employees, on employers, and on taxpayers. The following statistics provide concrete evidence of the negative impact that mandatory Social Security coverage would have on public school teachers in Chicago and the governmental bodies that contribute to their compensation.

FISCAL IMPACT STATISTICS

REGARDING CHICAGO PUBLIC SCHOOL TEACHERS AND CHICAGO BOARD OF EDUCATION

PROPOSALS:

Current proposals before Congress to alter the Social Security Act include proposals to:

> Impose Mandatory Medicare on all contributors to the Public School Teachers' Pension and Retirement Fund of Chicago at a rate of 1.45% of salary each for employer and employee, effective January 1, 1986.
>
> Impose Mandatory Social Security (including Medicare) on all new teachers hired after January 1, 1986 at a rate of 7.15% of salary for each employee and employer.

COMPARATIVE ONE YEAR COST:

If these proposals had been effective during the fiscal and school year ending August 31, 1984, the following costs would have been incurred:

Medicare deductions paid by employee	$ 10,385,094.56
Medicare payments paid by employer	$ 10,385,094.56
	$ 20,770,189.12
Social Security deductions paid by new new members . .	$ 1,097,358.47
Social Security payments paid by employer	$ 1,097,358.47
	$ 22,964,906.06

This $22,964,906.06 equals 4.5% of the gross salary paid to teachers during 1984. (These figures do not include comparable expenditures by and on behalf of career service employees employed by the Chicago Board of Education. Social Security payments and deductions include Medicare payments @ 1.45% and Social Security payments @ 5.7% of salary.)

FUTURE PROJECTIONS:

Under current law, the following increases in Social Security (OASDI) contribution rates are projected:

1986-1987 . . . 5.7%
1988-1989 . . . 6.06%
1990 & After . . . 6.20%

Medicare (HI) rates are expected to remain at 1.45% of salary.

It is important to note that the fiscal burden imposed upon the employer and the employee will spiral as years pass. For example, consider the potential impact of the extension of only Medicare to employees hired after January 1, 1986. During the first year, we project that Chicago Board of Education costs would equal $383,000 (matched by employee deductions from salary). By the year 2005, over $15 million would have to be budgeted for the employer-share costs of Medicare coverage alone.

The Fund's actuary has projected that, in the event of enactment of proposals to impose mandatory Medicare to all and mandatory Social Security to newly-hired employees, the following costs would be incurred by the Chicago Board of Education on behalf of teacher-employees matched by payments made by Chicago teachers.

Year	Social Security For New Employees	Medicare For All Employees	Total Cost for Employers or Employees	Combined Total Cost
1986	$ 1,506,000	$ 10,798,000	$ 12,304,000	$ 24,608,000
1987	2,950,000	11,264,000	14,214,000	28,428,000
1988	4,695,000	11,763,000	16,458,000	32,916,000
1989	6,430,000	12,283,000	18,713,000	37,426,000
1990	8,452,000	12,830,000	21,283,000	42,566,000
1991	10,451,000	13,406,000	23,857,000	47,714,000
1992	12,607,000	14,008,000	26,615,000	53,230,000
1993	14,943,000	14,638,000	29,581,000	59,162,000
1994	17,554,000	15,288,000	32,842,000	65,684,000
1995	20,362,000	15,970,000	36,332,000	72,664,000
1996	23,381,000	16,686,000	40,667,000	81,334,000
1997	26,682,000	17,438,000	44,066,000	88,132,000
1998	30,121,000	18,222,000	48,343,000	96,686,000
1999	34,005,000	19,038,000	53,043,000	106,086,000
2000	38,187,000	19,896,000	58,083,000	116,166,000
2001	42,694,000	20,798,000	63,492,000	126,984 000
2002	47,552,000	21,742,000	69,265,000	138,530,000
2003	52,699,000	22,732,000	75,431,000	150,862,000
2004	58,379,000	23,773,000	82,152,000	164,304,000
2005	64,474,000	24,866,000	89,340,000	178,680,000
			$856,081,000	$1,712,162,000

In view of these compelling statistics, and in consideration of the valid points discussed in the Board of Trustees' Resolutions in opposition to the imposition of mandatory Social Security in any form, we recommend that the Senate Budget Committee:

1. Examine the long-term actuarial impact of mandating Medicare or Social Security contributions. This will demonstrate that the long-term effects of such proposals will be to increase liabilities . . . not revenues.
2. Examine the fiscal burden imposed upon state and local governments resulting from these changes and consider how these employer costs are to be funded. This will demonstrate the undeniable reality that these proposals will result in tax increases or cut-backs in critical public services.
3. Consider alternative sources of revenue or alternative methods of cost savings -- to insure that current solutions to budget problems do not postpone federal problems while creating new ones for state and local governments.

Members of your committee may recall that, in 1983, the National Commission on Social Security Reform considered and rejected the idea of universal mandatory Social Security coverage. We endorse this conclusion and join with:

The National Conference on Public Employee Retirement Systems
The National Council on Teacher Retirement
The Confederation of Non-Social Security Systems
The United States Conference of Mayors
The National Association of Counties
The National School Boards Association
The National League of Cities
The International Association of Firefighters
The National Association of Government Employees
The City of Chicago, Office of the Mayor

and many other national, state, and municipal organizations and public employee retirement systems in opposition to the extension of mandatory Social Scuirty coverage in any form.

Sincerely,

Robert T. Wilkie

Robert T. Wilkie
President - Board of Trustees

On behalf of the Board of Trustees and
37,000 members of the Public School
Teachers' Pension and Retirement Fund
of Chicago

APPENDIX

APPENDIX #1*

Public School Teachers' Pension and Retirement Fund of Chicago
205 West Wacker Drive • Chicago, Illinois 60606
Telephone: 641-4464

Board of Trustees
BETTY BONOW
CLARK BURRUS
JUDY CHERIS
EDNA C. FANNING
MAE M. HUNTER
MARSHALL F. KNOX
ALBERT KORACH
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Officers
ROBERT T. WILKIE *President*
MARSHALL F. KNOX *Vice President*
MARGARET A. OLSON *Recording Secretary*
MAE M. HUNTER *Financial Secretary*

JAMES F. WARD *Executive Director*

August 30, 1985

President Ronald Reagan
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear President Reagan:

You said the federal government is too big. You said we should not make it bigger. Many Americans agree, yet . . .

A compromise budget resolution has instructed the House and Senate to raise $8 to $11 billion in new revenues to reduce the federal deficit. To do this, as early as September 17th the Senate Finance Comittee may write bills to force Chicago teachers into Social Security programs requiring additional taxes on them and on Illinois citizens. This could suddenly inflate local school budgets by tens of millions of dollars, jeopardize contract negotiations, and risk school closings if new taxes are mandated by January 1, 1986 as planned. And any actuary worth his salt will tell you the quick fix cash you collect today is only offset by the long-term liabilities you create.

Your tax change proposals would further lower benefits for Chicago teachers. We understand Ways and Means will also start writing this in September.

To lower federal budgets by raising ours is not limiting big government. Washington is simply getting bigger and sending us the bill while calling it "deficit reduction".

Can you help us, Mr. President? At the very least, such extensive changes should not be so rapidly enacted with 1986 effective dates.

I remind our 37,000 members in Chicago, in Illinois, and across the nation to express their feelings on these matters to you and their legislators in Washington. Hoping this finds you fully recovered and enjoying good health.

Sincerely,

Robert T. Wilkie

Robert T. Wilkie, President
Board of Trustees

cc: 27,000 teachers, 9,700 annuitants
and other interested parties

APPENDIX 2A

Public School Teachers' Pension and Retirement Fund of Chicago
205 W. Wacker Drive • Chicago, Illinois 60606

Mandatory Social Security Coverage for Public Employees

WHEREAS, In 1950 the Social Security Act was amended extending Social Security coverage to public employees not included in a state or local public retirement system, and

WHEREAS, Eight states, in order to qualify, repealed existing retirement statutes and placed public employees under Social Security, and

WHEREAS, In 1954 and 1956 further amendments provided voluntary Social Security coverage for public employees based on referenda conducted in the several states on a unit or divisional basis, and

WHEREAS, Under these amendments, Social Security coverage was adopted by many states for public employees, and

WHEREAS, A number of states, relying on the historical voluntary provisions in the Social Security Act as regards public employees, have chosen to provide excellent programs of retirement, and

WHEREAS, Mandated Social Security coverage in addition to these programs creates a cost liability exceeding the resources of employees and taxpayers, resulting in drastic restructuring or abandonment of many excellent programs, and

WHEREAS, The issue of mandatory Social Security participation by federal, state and municipal public employees is being contemplated by the Congress, and

WHEREAS, There are serious constitutional questions raised by mandatory Social Security coverage for employees of governmental units, now therefore be it

RESOLVED, That the Board of Trustees of the Public School Teachers' Pension and Retirement Fund of Chicago opposes extension of Social Security coverage to public employees by mandate of the Congress or through any method other than voluntary coverage based on referenda conducted as provided in present law.

Ratified February 17, 1983
by the Board of Trustees of
the Public School Teachers'
Pension and Retirement Fund
of Chicago

Public School Teachers' Pension and Retirement Fund of Chicago
228 North La Salle Street, Chicago, Illinois 60601

APPENDIX 28

RESOLUTION FAVORING REPEAL OF THE SOCIAL SECURITY OFFSET PROVISION

At their September 17, 1981 Board Meeting, the Trustees of the Public School Teachers' Pension and Retirement Fund of Chicago ratified the following resolution, expressing their position in favor of the repeal of the offset provision of current Social Security law.

> WHEREAS, Public Law 95-216 of 1977 established a provision whereby the Social Security survivor's benefit for a beneficiary whose benefit begins after December 1, 1982 shall be offset by the amount of benefits drawn from a public retirement system on behalf of the beneficiary, where public employment of the beneficiary was not covered by Social Security; and
>
> WHEREAS, This offset provision is discriminatory to recipients under public retirement systems because it does not apply to recipients under private retirement systems; and
>
> WHEREAS, There is no legal or actuarial justification for offsetting benefits in one system based upon eligibility in another system provided they both are earned and funded in accordance with the legal requirements of each system; now, therefore be it
>
> RESOLVED That the Board of Trustees of the Public School Teachers' Pension and Retirement Fund of Chicago does hereby express its strong position in favor of repeal of the Social Security offset provision; and, be it further
>
> RESOLVED, In recognition that legislation to repeal the offset provision may not be accomplished prior to the effective date, December 1, 1982, we strongly urge the passage of a five-year extension of the effective date, until November 30, 1987, such as proposed under H. R. 7313 by Congressman Ronald M. Mottl, Ohio, and supported by Congressman J. J. Pickle, Texas, Chairman, Committee on Social Security, Ways and Means Committee; and be it further
>
> RESOLVED That a copy of this resolution be forwarded to selected members of the Congress, to the Secretary of Health and Human Services, and to the Director of the Social Security Department, and further, that a personal letter be sent to Congressmen Mottl and Pickle expressing appreciation for their interest and support.

. . . .

RATIFIED BY

THE BOARD OF TRUSTEES

Judy Cheris
Edwin Claudio
John D. Foster

Mae M. Hunter
Martha J. Jantho
Marshall F. Knox

Albert Korach
Margaret A. Olson
Robert T. Wilkie

September 17, 1981
DATE OF PENSION BOARD MEETING

The Railroad Retirement Association
210 7th Street, S.E., Suite 517
Washington, D.C. 20003
(202) 546-5856

STATEMENT

OF

THE RAILROAD RETIREMENT ASSOCIATION

TO

THE COMMITTEE ON FINANCE

OF

THE UNITED STATES SENATE

FOR

SEPTEMBER 13,1985
COMMITTEE HEARING

ON

FISCAL YEARS 1986-88 BUDGET RECONCILIATION ISSUES
AFFECTING RAILROAD RETIREMENT
AND
RAILROAD UNEMPLOYMENT INSURANCE

L. L. Duxbury
President

This non-profit association is a voluntary individual membership association of railroad retirees, their spouses and dependents and of individuals with fully vested rights in the Railroad Retirement System. The association is not, in any way, affiliated with nor supported by any element of rail labor or of the railroad industry. It is a completely independent association.

It is our understanding that the issues to be considered at this hearing include the following recommendations:

1. The Administration's Budget proposals as to Railroad Retirement and its benefits, including the proposal to raise additional revenue by increasing the federal income tax liability of some Railroad Retirement beneficiaries.
2. The Administration's Budget proposals as to the Railroad Unemployment Insurance System and the provisions for payment of the debt owed the Railroad Retirement Fund by that System.
3. The recommendations in the June 29,1984 Report of the Railroad Labor-Management Unemployment Compensation Committee, established by Section 504 of the Railroad Retirement Solvency Act of 1983, Public Law 98-76, including the recommendation that interest be forgiven or waived on the multi-hundred million dollar debt of the Railroad Unemployment Insurance Account to the Railroad Retirement Fund.
4. The recommendation in the"SIXTEENTH ACTUARIAL VALUATION of the Assets and Liabilities Under the Railroad Retirement Acts as of December 31,1983,"recently issued by the Railroad Retirement Board, that one percent of the present Tier II tax on the industry be diverted to payment of the Railroad Unemployment Insurance debt to the Railroad Retirement Fund.

Each of those recommendations involves one or more provisions of the above cited 1983 law, Public Law 98-76 , passed by the Senate August 2,1983 , "as is ", without change, at the request and urging of not only rail labor and rail management, but also OMB, all as fully appears in Senate Committee on Finance Hearing Record No.98-272, dated August 2,1983 and also in the Senate Record for August 2,1983. On August 2nd the Senate passed, as is and without change, the exact same bill passed by the House August 1st.

Before passing the bill August 1st, the House made significant changes in the bill recommended by the House Committee on Ways and Means. Atttached hereto as

EXHIBIT I is a copy, from page 63 of Senate Committee on Finance Hearing Report No. 98-272 dated August 2,1983, of the table presented to the Committee at that hearing to explain the changes recommended by the House Committee on Ways and Means and adopted by the House before final House passage.

In its Report No.98-30 part 2 on the legislation the House Committee on Ways and Means characterized its recommended changes as providing " an additional $1 billion in revenues to the railroad retirement and unemployment compensation systems between fiscal years 1984 and 1989. This additional revenue will substantially increase the likelihood that the Railroad Retirement Account will be able to meet benefit obligations for the foreseeable future, reduce the need of the unemployment compensation system to borrow from the Railroad Retirement System, and allow for at least partial repayment of the unemployment compensation system's debt to the Railroad Retirement System." (Pages 19-20 of said Report).

In addition to increased Railroad Retirement Tier II taxes on the railroad industry, the significant changes recommended by the House Committee on Ways and Means and approved by the House and the Senate included the imposition of a new tax on industry to raise revenue to apply on the Unemployment Compensation System's debt to the Railroad Retirement Fund, a new tax in addition to the Railroad Retirement Tier II tax on the industry and the Unemployment Compensation tax on the industry.

On pages 39-40 that above-mentioned Report No.98-30 part 2 stressed the importance of the imposition of that new tax in the following report language:

> " Equally important, the imposition of the repayment tax contained in this section demonstrates the intent of the Committee on Ways and Means to insure and, if necessary,provide for the repayment of all loans from the Retirement Account. Should the RRUC Committee ... fail to provide an acceptable procedure for the repayment of outstanding loans, it is the intent of the Committee on Ways and Means to make the repayment tax contained in this section permanent, as well as make other necessary modifications that will assure repayment of all RRUC debts by the end of the year 2000."

The Table in EXHIBIT I shows the dollar effects of the changes in the final bill, changes recommended by the House Ways and Means Committee. OMB opposed the version of the bill detailed in the figures in the first column in that table. OMB not only supported the final version, detailed in the second column of figures, but urged the Senate to pass the bill, as is and without change, as did both rail labor and rail management.

Now rail labor, rail management and OMB are asking the Congress to make significant changes in that 1983 law, just two years after they asked and urged Congress to pass it.And what would they have Congress do?

RAIL LABOR AND RAIL MANAGEMENT : FORGIVENESS OF INTEREST ON UNEMPLOYMENT INSURANCE DEBT TO RAILROAD RETIREMENT FUND AND/OR DIVERSION OF PART OF RAILROAD RETIREMENT TIER II TAX TO PAYMENT ON THAT DEBT

Any distinction between forgiveness of interest and diversion of part of the Tier II tax is a distinction without a difference- the result is the same, less revenue to the Railroad Retirement Fund, reduction in the amount contributed by industry under the 1983 law, reduction in industry's share of the burdens under that law. At the same time leaving the burdens of the other groups under that law unchanged.

It cannot be disputed that the law has always provided for interest on loans from the Railroad Retirement Fund to the Unemployment Insurance Account and so provided at the time of each of the loans making up the present debt. Section 10(d) of the Railroad Unemployment Insurance Act provides that repayments of loans from that Fund shall be " plus interest at a rate for each fiscal year equal to the average rate of interest borne by all special obligations held by the Railroad Retirement Account on the last day of the preceding fiscal year."

There has been a contention in some quarters that in the consideration and passage of the 1983 law Congress " contemplated ",or at least considered the possibility, that interest on that debt might be waived.There doesn't seem to be anything in the 1983 law itself or the legislative history of that law that can be construed as support for that contention. On the contrary, Section 232 of the 1983 law,an entirely new section in the law and not an amendment of existing law, contains a definition of " RAILROAD UNEMPLOYMENT LOANS " for the purposes of the new debt repayment tax, as follows: " The term ' railroad unemployment loans ' means transfers under section 10(d) of the Railroad Unemployment Insurance Act from the Railroad Retirement Account to the Railroad Unemployment Account. The outstanding balance of such loans shall include any interest required to be paid under such section 10(d)."

OMB : IN THE NAME OF DEFICIT REDUCTION INCREASE THE AMOUNT OF FEDERAL INCOME TAX LIABILITY OF ABOUT 406,000 RAILROAD RETIREES A TOTAL OF ABOUT $289 MILLION OVER THE 1986- 1990 PERIOD

Estimates indicate that this proposal would increase the income tax liability of the affected group of rail retirees by a total of $161 million over the 1986-1988 period. That would increase the total burden on retirees from the new tax on those benefits from $960 million to $1.21 billion over the 1984-1988 period under the 1983 law, and increase the total for the retiree group in the second column of the table in EXHIBIT I from $2.200 billion to $2.361 billion over that period.

Each of the above recommendations involve and affect the equities of the 1983 law. Retirees earnestly and respectfully contend that due consideration of each of those recommendations can be made only in connection with, and as part of, a full and complete examination of the equities of the 1983 law.

Ever since the passage of the 1983 law the Railroad Retirement Board has been extolling the equity and fairness of that 1983 law (which, in Board parlance, is " The Solvency Act") in letters to members of Congress and retirees and in some official Board Reports in the following characterization of that Act: " The Solvency Act was a compromise. It contains many elements, and they are interrelated. The sacrifices made by each group is a trade-off for the sacrifices asked of every other group. If any part is rescinded, the risk is created that the whole package will unravel."

Does forgiveness of interest on the debt to the Railroad Retirement Fund create the risk ? Does diversion of part of the Railroad Retirement Tier II tax create that risk ? What affect does increase in the income tax liability of some of the retirees have on the " trade-offs " in that 1983 law ? Does tax diversion or interest forgiveness affect those " trade-offs " ?

The reduction in the amount of the Tier II benefit of pre-1984 retirees under the 1983 law (the fourth item from the top in the EXHIBIT I table) will increase from $920 million for the 1984-1988 period to $2.311 billion for the period ending with the year 2000.That 1983 law does not reduce the Tier II benefits of those retiring after 1983.

Another significant change made by the House Ways and Means Committee was particularly costly for the pre-1984 retirees.That change involved the provisions of the bill subjecting the Tier II benefit to federal income taxes for the first time. The bill as approved by the House Committee on Energy and Commerce specifically provided that:

" For purposes of determining the amount of employee contributions recovered in the annuity, the annuity would be considered as beginning on January 1,1984. The taxation of these benefits would begin on January 1,1984." (House Committee on Energy and Commerce Committee Report No.98-30, part 1, page 50)

On the House floor August 1 those provisions were changed in such a way as to retroactively change the status for income tax purposes of Tier II benefits received before January 1,1984, the effective date of the new income tax on those benefits.

As appears from the EXHIBIT I table, that change cost the pre-1984 retiree group an additional $310 million in income taxes. That change is now water over the bridge and the effect of it cannot be undone, but that additional burden on that group is one of the factors which must be taken into consideration in weighing the equities of that 1983 law.

Based on the figures in the EXHIBIT I table, the total loss in income for the retiree group averages out to about $400 per year per retiree-recipient over the fiscal 1984-1988 period under the 1983 law. For states with at least 2500 resident retiree- recipients that total income loss under the 1983 law over the fiscal year 1984-1988 period averages out per year as follows (in millions) :

Alabama	$6.0
Arizona	5.4
Arkansas	5.2
California	28.0
Colorado	5.2
Connecticut	2.4
Delaware	1.2
Florida	19.3
Georgia	8.7
Idaho	2.4
Illinois	26.4
Indiana	10.4
Iowa	6.4
Kansas	8.5
Kentucky	8.9
Louisiana	$ 5.2
Maine	1.9
Maryland	7.0
Massachusetts	5.1
Michigan	8.6
Minnesota	10.8
Mississippi	3.6
Missouri	13.6
Montana	3.2
Nebraska	5.5
Nevada	1.4
New Jersey	9.5
New Mexico	2.8
New York	21.4
North Carolina	$ 5.9
North Dakota	1.7
Ohio	21.3
Oklahoma	3.8
Oregon	5.4
Pennsylvania	32.4
Tennessee	8.2
Texas	20.9
Utah	3.8
Virginia	11.4
Washington	6.6
West Virginia	4.5
Wisconsin	5.4
Wyoming	1.8

Wouldn't each of those states welcome with open arms, and do everthing possible to encourage and assist, any prospective new employer who would add those respective amounts to the spendible income in the state each year ?

Rail retirees welcome, in fact have been requesting, a full examination of the equities of that 1983 law ever since it was passed in August 1983. In the last Congress retirees requested and supported legislation which would have restored the second cut, made January 1,1985, in the Tier II benefit of pre-1984 retirees. In this Congress retirees are wholeheartedly supporting S.929, introduced by Senator Heinz April 17,1985. Attached hereto and marked EXHIBIT II is a copy of the introductory remarks of Senator Heinz as to that bill from the April 17, 1985 Senate Record.That bill would restore the second cut under the 1983 law in the Tier II benefit of pre-1984 retirees. As Senator Heinz states in his introductory remarks: " In my opinion, the reduction in railroad retirees benefits this year was unwarranted, and we should restore the money the Government took away." ..." In my judgment railroad retirees deserve a better shake."... " I think we owe a full COLA to all railroad retirees. "

Senator Heinz' bill would restore only the second cut in Tier II benefits, which cut was made January 1,1985, not the first cut, which was twice as large as the second cut and was made January 1,1984.

In the House Congressman Shuster (PA) has introduced HR 1835 to restore that second cut.There are indications of rail labor support for both the Heinz and Shuster bills.

Retirees seek only equity and respectfully contend that in the present situation, viewed from every possible angle, equity calls for retoration of that second cut under that 1983 law.Also equity would suggest that proposals for changes in that 1983 law should not be considered or acted upon separately, but in connection with, and as part of, a full examination of the equities of that 1983 law.That 1983 law has been in effect now for two years, and the Congress can have the benefit of the full effect of the full implementation of that law over a two year period , and, based thereon, the benefit of projections as to the future effect of that law, both as is and with various suggested changes.

There is NO BONANZA, NO FREE RIDE, in Railroad Retirement. From the start, Railroad Retirement taxes were, and continue to be, higher than Social Security taxes, the initial tax being two and three-quarters times the then Social Security tax rate.By an 1951 law, Social Security and Railroad Retirement were fully coordinated dollarwise, and the Social Security Fund was put in the exact same condition as it would have been if railroad employees had been covered by Social Security from the start, back to January 1, 1937. The total 1984 Railroad Retirement benefit(Tier I plus Tier II) averaged $643.18 monthly. By comparison and contrast, the 1985 federal civil service pension will average $1,000 monthly. The Railroad Retirement 1985 Tier II benefit will average only $500 monthly.

Table I

Comparison of Proposals 1/

	FY 84-88 Amount ($ in millions)		Share of Total (%)	
	Rail Labor/ Management Request	House Bill	Rail Labor/ Management Request	House Bill
Retirees :				
Early retirement reform 2/	350	150	4%	2%
5 month DI waiting period	130	80	1%	1%
Tier II COLA postpones	70	60	1%	1%
Attribute 5% of Tier I COLA to Tier II	920	920	9%	10%
Tax industry pension and windfall benefits under IRC rules	650	960	7%	10%
Student benefit phase-out	30	30	--	--
SUBTOTAL	2,130	2,200	22%	24%
Rail Employees				
2.25% contribution increase 84-86	760	910	8%	7%
Annualize Tier I wage base	---	80	--	3%
SUBTOTAL	760	990	8%	11%
Rail Management				
3.5% contribution increase 84-86 3/	1,130	1,250	11%	13%
Annualize Tier I wage base security and accelerate deposits	-----	280	--	3%
RUI contribution increases and debt repayment	-----	470	--	5%
SUBTOTAL	1,130	2,000	11%	21%
Rail Sector Total, Retirees, Employees, Management	4,020	5,190	41%	56%
Federal Government				
Windfall	2,070	2,070	21%	22%
UI borrowing	1,800	-----	18%	--
General fund borrowing against financial interchange 2/	2,000	2,000	20%	22%
SUBTOTAL	5,870	4,070	59%	44%
GRAND TOTAL	$ 9,950	$ 9,260	100%	100%

1/ Pricing based on CBO estimates except where noted.
2/ Based on RRB estimate
3/ Includes effect of annualizing Tier II wage base

EXHIBIT I

EXHIBIT II

By Mr. HEINZ :

S.929. A bill to amend the Railroad Retirement Act of 1974 to eliminate the COLA offset provisions, and restore amounts offset under those provisions after January 1984; to the Committee on Labor and Human Resources.

RAILROAD RETIREMENT COLA RESTORATION

Mr. HEINZ. Mr.President, today I am introducing legislation to return to railroad retirees the money that was unnecessarily taken away from them this past January. My bill would restore to retirees the 1.5 percent COLA subtracted this year from tier II benefits, retroactive to January 1985.

In 1983, when the railroad retirement system was on the brink of insolvency, rail labor and management negotiated, and Congress enacted a comprehensive financing package to restore solvency to the system. This rescue package called for contributions from three major parties- the railroad industry, employers, and employees; the Federal Government; and railroad retirees- in order to shore up the system's short-and long-term financial integrity.

For retirees, the bulk of their contribution came from the so-called COLA offset which required that the next 5 percent of their tier I- Social Security equivalent-COLA increases be deducted, dollar for dollar, from their tier II- industry pension equivalent- benefits. Due to this change, in January 1984 the 3.5 percent COLA given to Social Security beneficiaries was taken away, in full, from railroad retirees' tier II checks. In January 1985, the 3.5 percent Social Security increase was effectively reduced to 2 percent for railroad retirees, due to the second phase, 1.5 percent, of the COLA offset.

In my opinion, the reduction in railroad retirees' benefits this year was unwarranted, and we should restore the money the Government took away. When Congress passed the Railroad Retirement Solvency Act in 1983, it was working under very pessimistic assumptions about the future of both the railroad industry and the national economy. As it turns out, both have performed far better than expected in the past 2 years, and the railroad retirement trust fund is rapidly accumulating surpluses. From the standpoint of the financial solvency of the system, the money saved from the second phase of the COLA offset is overkill.

Mr. President,on January 24,1985,the members of the Railroad Retirement Board sent a letter to President Reagan projecting the financial condition of the railroad retirement system through 1990,under two alternative sets of assumptions. Assumption A is considered a moderate estimate; assumption B a very pessimistic scenario. I would like to include in the Record a table from this letter that outlines the financial status of the trust fund under these assumptions.

(Employment in thousands, dollars in millions)

Calendar year	Employment		Fund balance	
	Assumption A	Assumption B	Assumption A	Assumption B
1985 ------------	385	375	$3.920	$3.843
1986 ------------	371	351	5.547	5.338
1987 ------------	364	342	6.422	6.024
1988 ------------	361	336	7.133	6.474
1989 ------------	347	314	7.610	6.688
1990 ------------	334	295	8.011	6.747

What this table shows is that even under extremely conservative assumptions about the future of the economy and the railroad industry, the railroad retirement system is building up billions of dollars in excess reserves. With this kind of surplus, I don't think it is fair to impose any more financial hardship on retirees who have already sacrificed a great deal.

Railroad Retirees have been hit very hard in the past few years. In 1983, they were socked with a 6-month delay in their COLA due to the Social Security Amendments of 1983. In 1984, their tier I COLA was lost altogether due to the first phase of the COLA offset, and in 1985, retirees were forced to forego a major part of their tier I COLA due to the second phase of the offset.

In my judgment, railroad retirees deserve a better shake. They have paid taxes throughout their working lives, and they deserve a fair benefit, protected against inflation. Given the excellent financial health of the railroad retirement system, we can clearly afford to give back to retirees part of the surplus they helped to create. Economic recovery has certainly benefited railroad employers and employees. I think we owe a full COLA to all railroad retirees.

Mr. President, I urge my colleagues to support this legislation, and recommend its quick enactment.

(Note : The foregoing EXHIBIT II is a copy, from the United States Senate Record of April 17, 1985, of the Remarks of Senator Heinz upon the introduction of S. 929 .)

The Railroad Retirement Association
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(202) 546-5856

September 16,1985

Honorable Bob Packwood
Chairman, Committee on Finance
United States Senate
Washington, D. C. 20510

Dear Chairman Packwood:

Re: Railroad Retirement and Railroad
Unemployment Insurance Deficit
Reduction Issues

By this letter this association hereby submits, for inclusion in the Hearing Record, a supplement to the association's statement heretofore submitted on the above-described issues which were the subject of September 13 Committee Hearings.

Just two years ago, rail retirees were threatened with a forty percent cut in their Tier II pension benefit , effective October 1, 1983, because, as they were told, the financial condition of the Retirement Fund was so bad that the threatened cut was unavoidable.

Thus, the 1983 law. That law did not start to have an effect on the Retirement Fund until January 1, 1984. In less than 6 months, from January 1,1984 to June 29,1984 (the date of the labor-management Railroad Unemployment Insurance Committee Report) the Retirement Fund had attained such financial soundness under that 1983 law that that labor-management committee could recommend reducing the industry's share of the burdens under that 1983 law by the amount of the interest the law would require the industry to pay on the Insurance account debt to the Retirement Fund.

And this all without any part of the Insurance Account debt having been paid. At the time the cut threat was made in 1983, the Railroad Retirement Board admitted that that cut would not havehad to be threatened if it weren't for the Insurance Account debt to the Retirement Fund. Subsequently, that debt was increased by additional automatic loans; also after June 29, 1984.

The Retirement Fund had become so sound financially that just this past April the Railroad Retirement Board Chairman stated publicly that the Retirement Fund would be " OVER-FUNDED " by $2 billion if the industry were required to pay interest on that debt as provided for in the law.

The Office of Management and Budget characterized the labor-management insurance committee recommendations as " robbing Peter- the pension fund- to pay Paul- RSUI ", and as calling on the pension fund " to bail-out RSUI. "OMB concluded that those recommendations"would take between $.7 billion to $2.9 billion from the rail industry pension fund, effectively transferring it io the RSUI fund by forgiving all interest owed the pension fund."

One has to wonder when the Railroad Retirement Board first knew that payment of interest on that debt as provided for in the law would create a $2 billion surplus in the Retirement Fund. The labor member of the Board and the management member, accompanied by the Chief Actuary for the Board, appeared before a House Subcommittee early in 1983 in support of the 1983 legislation. Nowhere in the hearing record is there any indication by anyone of the three that payment of interest on that debt would result in a surplus of $2 billion.

Although the House bill as amended by the Committee on Ways and Means clearly intended that interest should be paid on that debt, a report on that legislation by that Chief Actuary to the Board members setting forth the projected fund balances through 1992, which report was used in the debate on the House bill on the House floor August 1,1983 , does not in any way indicate any surplus if interest is paid on that debt. That report appears on page H 6143 of the August 1,1983 House Record.The same statistical information appears in a memorandum prepared by that Chiel Actaury set forth on pages (45) and (46) of House Ways and Means Committee Report No.98-30, part 2.

The table used in the Senate Committee on Finance August 2,1983 Hearing on the on the 1983 legislation, which table is set forth at pages 3 and 4 and page 63 of that Committee's S. Hearing 98-272 and which table is attached as Exhibit I to this association's original statement, clearly took into account the interest on that debt as provided by law. The $1,800,000 figure , which is the fourth figure from the bottom of the first column of that table, clearly includes interest on the debt.

That Chief Actuary memorandum was also used in the consideration of the bill on the Senate floor and appears at pages S 11326 - 7 of the Senate Record for August 2, 1983.

Even more strange is the Board's decision in its SIXTEENTH ACTUARIAL VALUATION Report to omit the Insurance Account debt as an asset in the Retirement Fund. Also, that Report contains no indication that the payment of interest on that debt will create a $2 billion surplus in the Retirement Fund, but the Board does recommend reducing the industry's tax obligations under the 1983 law by diverting toward payment of the Insurance Account debt one percent of the Tier II tax on the industry . Such a diversion would reduce the revenue of the Retirement Fund by about $ 100 million per year, plus the interest that would be lost each year on each yearly diversion. Over a 15 year period the cumulative total loss to the Fund would be about $2.5 billion. What happened to that Fund over the 1983 - 1985 period to make such a large diversion " feasible " ?

SOURCE AND AMOUNT OF INCREASE IN BALANCE IN THE
RAILROAD RETIREMENT FUND 1983-85 UNDER 1983 LAW

REDUCTIONS OF RETIREE BENEFITS (a)	1983	1984	1985	CUMULATIVE TOTAL
COLA DEFERRAL AND REDUCTION IN AMOUNT OF TIER II BENEFIT	$ 45	222	306	573
DISABILITY WAITING PERIOD	3	20	24	47
STUDENT BENEFIT PHASE - OUT	0	3	5	8
SUBTOTAL	48	245	335	628
NEW INCOME TAXES ON RETIREE BENEFITS				
INCOME TAX ON TIER II BENEFITS	0	50	171	221
INCOME TAX ON " WINDFALL BENEFITS "	0	13	42	55
INCOME TAX ON SICK - PAY BENEFITS	0	8	11	19
SUBTOTAL	0	71	224	295
RETIREE GRAND TOTAL	48	316	559	923
INCREASE IN EMPLOYEES TIER II TAX (b)	0	16	127	143
EMPLOYEE TOTAL	0	16	127	143
INCREASE IN INDUSTRY TIER II TAX (b) (c)	0	17	140	157
INDUSTRY TOTAL	0	17	140	157
FEDERAL "WINDFALL" PHASE-OUT FUND PAYMENTS(d)	0	642	690	1,332
FEDERAL TOTAL	0	642	690	1,332
GRAND TOTAL - ALL SOURCES	$ 48	991	1,516	2,555

(a) and (b) Reduction in early retirement benefits not included. The reduction was reduced on the House floor and the Tier II taxes on employees and the industry were increased in an amount equal to the cost of the change to the Fund. The figures for the annual amounts of the net reduction are not available nor are the annual figures for the offsetting Tier II tax increases.

(c)The Unemployment Insurance tax increase for the industry under the 1983 law is not included because the proceeds of that tax are not revenue to the Retirement Fund.The increase is 0 in 1983; $36 million in 1984;and $73 million in 1985.

(d) These payments are intended to make up the shortfall in prior federal payments to the fund for the phase - out of the so - called " windfall benefits ." The third and final payment will be made in 1986 in the amount of $737 million.

The percentage shares of the four sources of the $2.555 billion increase in revenue to the Retirement Fund under the 1983 law during the 1983 - 1985 period are as follows :

Increase in industry Retirement Fund taxes		6.0 %
Increase in working employees Retirement Fund taxes		6.0 %
Reduction in retiree benefits	24.5 %	
New income taxes on retirees' benefits	11.5 %	
Total from retirees		36.0 %
Federal Government		52.0 %
	Total	100.0 %

One simple conclusion stands out : there could be no thought of forgiveness of interest due the Retirement Fund or diversion of other Retirement Fund revenue, if it weren't for the income of retirees diverted to that Fund by the provisions of the 1983 law reducing retirees' benefits and subjecting their benefits to income taxes for the first time; nor could there be any thought of either, if it weren't for the catch - up payments to that Fund by the Federal Government on the funding of the phase - out of the so-called " windfall benefit ."

During the 1984 - 1990 period just one of the retiree benefit cuts, the cut in the amount of the Tier II benefits of pre - 1984 retirees under that 1983 law, will cost that retiree group $ 1.250 billion in loss of income. During the 1983 - 2000 period that loss of income to that one group will increase to $ 2.506 billion from that one benefit cut.

Based on the sources and respective amounts of the contributions to the increase in the balance in the Retirement Fund , creating what is now called a " surplus ", is there any fairness in, can there be any justification for, in effect diverting part of that surplus to the Unemployment Insurance Account by either forgiving interest which that Account owes that Fund on an unpaid debt, or diverting future tax revenue due that Fund in such a way as to let that Account use that diverted Fund revenue to pay the Account's debt to the Fund? Wouldn't it be nice if one could work out an arrangement of that kind with one's banker ?

Retirees sincerely feel that the financial burdens on them under the 1983 law were enormous, if not horrendous. They feel that they did not get a fair shake under that 1983 law . Interest forgiveness or tax diversion will add salt.

Now retirees have reason to be convinced that they did not get a fair shake under that 1983 law , that the cuts they they have suffered,and will continue to suffer under that 1983 law,were deeper than they needed to be, in view of the " surplus " created by that 1983 law in just two years .They also know now that if the Railroad Retirement Board had included in the Fund projections which the Board provided for Congressional consideration of the 1983 legislation,that Account debt to the Fund and interest on that debt as provided for in the law, the excessiveness of those cuts would have been obvious to all.

All along retirees have sought , and continue to seek, only equity . How would the principles of equity dispose of a " surplus " created in the way that the present alleged " surplus " in the Retirement Fund was created ? Wouldn't equity suggest a full examination of the equities of that 1983 law for the purpose of determining what changes , if any , should be made in that law from this point forward ?

HR 3128 as recommended by the House Ways and Means Committee would increase the the income tax burden of about 406,000 retirees to raise additional federal revenue as a contribution to the reduction of the federal deficit . It would appear that group of rail retirees would be the only Americans subjected to a federal income tax increase for that purpose , even though there are , according to published reports, a relatively large number of individuals, with substantial incomes,who pay little or no federal income tax,and even though there are large corporations with substantial net income, which not only paid no federal income tax, but received substantial federal income tax refunds . Is that equitable ? It will increase the burden of that group of retirees under the 1983 law as follows(in millions) : 1986 - $34; 1987 - $62; 1988 - $65; 1989 - $65; 1990 - $63 .

HR 3128 recommends increased taxes for additional revenue to apply on the Account debt to the Retirement Fund, but those taxes will not raise sufficient revenue to pay that debt in full with interest.When the debt repayment taxes in that proposal expire September 30, 1990, about $430 million of that debt would then remain unpaid . Hr 3128 would raise a total of about $ 522 million ,$200 million in addition to the amount which the present provisions of the 1983 law would raise , over the 1986 - 1990 period. All of it is really money for the Unemployment Insurance Account, to be used by that Account to apply on its debt to the Retirement Fund.It is not revenue to the Retirement Fund , except the interest portion.

Sincerely and Respectfully,

L. L. Duxbury

SCHOOL EMPLOYEES RETIREMENT SYSTEM OF OHIO

STATEMENT IN OPPOSITION TO MANDATORY SOCIAL SECURITY AND MEDICARE TAX

The Board of the School Employees Retirement System of Ohio is strongly opposed to current proposals now before Congress to require Social Security coverage for new public employees and to institute a tax on public employees and employers to pay for Medicare.

The Board believes that any revenue advantages to the federal treasury are far outweighed by the overwhelming negative impact which these proposals will have on Ohio's efforts to finance a system of quality public education.

These proposals, particularly mandatory Social Security coverage, would have the following effects:

1. The School Employees Retirement System would suffer a significant decline in membership, thus eventually destroying our main revenue source. The System's actuaries have estimated school boards would have to pay another 10% of payroll, in addition to the current 14%, to replace the lost revenue.
2. A Medicare tax of 1.45% would cost Ohio school boards $10 million annually just for nonteaching employees. Mandatory Social Security would place an additional annual financial burden of over $73 million on school boards to cover benefits to retired employees and vested benefits of current workers.
3. Mandatory Social Security coverage will only marginally reduce the federal deficit at the expense of public education in Ohio and without consideration to the long-term liabilities of the Social Security Trust Fund.

The effects of mandatory Social Security and a Medicare tax are explained more fully in the following text.

Mandatory Social Security Will Cause Substantial Liabilities

The School Employees Retirement System (SERS) is a public retirement system created by the Ohio General Assembly in 1937 to provide retirement income security for nonteaching school employees. The System has continued to provide comprehensive benefits to 40,000 retired employees within a sound actuarial framework.

In addition to service pensions, SERS' benefit package includes disability and survivor benefits and health care insurance. These benefits are funded solely by mandatory payroll contributions of 14% from employer school boards and 8.75% from employees. In determining the level of benefits and contributions, modest growth in both new members and school district payrolls are assumed by the System's actuaries.

If all new school employees were to be placed under Social Security instead of SERS, the stagnant membership base results in the eventual destruction of the fund's revenue. Should SERS become a "closed system" in 1986, actuaries have projected a 50% loss in membership over the succeeding ten-year period.

Such a dramatic cutback in revenue forces either a correspondingly drastic increase in contribution rates or a drastic reduction in the benefits promised to current members. The SERS Board believes neither alternative is acceptable to employers and members.

Members who have vested rights to benefits set by Ohio law and Retirement Board rule have every right to the security these benefits will provide in their retirement years. SERS believes the financial stability of the fund has inspired the highest confidence of our members that promised benefits will be paid. The Board feels a strong obligation to maintain that confidence by not being forced to reduce these promised benefits.

Mandatory Social Security And A Medicare Tax Will Cost Ohio School Boards Over $83 Million Annually

However, it is unrealistic to ask employer school boards in Ohio to pay the price necessary to fund these benefits should all new employees be covered by Social Security.

SERS actuaries have determined that a 10.05% increase in the employer contribution rate is required in the event there is zero growth in retirement system membership. This is an additional $73 million annual cost to Ohio school boards for their nonteaching employees. The added cost for teaching personnel would carry an even higher price tag.

Even the imposition of a 1.45% payroll tax for Medicare coverage would strain school budgets. At an estimated annual cost of over $10 million, school boards would be required to pay for a benefit that 98% of their SERS employees have already earned. Ultimately, it is Ohio taxpayers who would be asked to fund these additional financial liabilities under the guise of reducing the federal deficit and deficiencies in the Social Security Trust Fund.

Creative Bookkeeping Will Not Solve The Federal Deficit

While mandatory Social Security and Medicare taxes would provide "quick fix dollars" to reduce the federal deficit, ultimately long-term liabilities will be created for the Social Security Trust Fund. It has been estimated that mandatory Medicare taxes for newly hired public employees would generate only about $500 million over a three-year period. The Social Security Trust Fund would be an estimated $2.6 billion richer over the same three-year period should new public employees be placed under Social Security. Such amounts are minimal when compared to the increased long-term liabilities which would be imposed on the Social Security System and the increased financial burdens imposed on public employers and employees.

Considering Social Security as part of the deficit has been labelled a "bookkeeping gimmick." Creative bookkeeping cannot justify the irreparable harm to Ohio's public school system, its employees and taxpayers.

School Employees Retirement System
45 North Fourth Street
Columbus, Ohio 43215-3634
Thomas R. Anderson, Executive Director

STATE TEACHERS RETIREMENT SYSTEM OF OHIO

WRITTEN STATEMENT OF OPPOSITION TO MANDATORY SOCIAL SECURITY AND MANDATORY MEDICARE FOR STATE AND LOCAL GOVERNMENT EMPLOYEES TO THE UNITED STATES SENATE COMMITTEE ON FINANCE

1. The State Teachers Retirement System of Ohio (STRS) for public school and university teachers of this state began operations September 1, 1920, to provide retirement, disability, and survivor benefits for its members. These income security programs have been improved over the years and now a full range of medical benefits is included.

2. It was not until the mid 1950's that Ohio teachers were permitted to participate in the Social Security program. Long before that time, this system provided a benefit structure superior to that of the Social Security system. Ohio teachers who were at one time banned from participating in Social Security developed their own plan and do not want to participate in Social Security and additional Medicare coverage.

3. Ohio STRS is funded on an actuarial reserve basis; Ohio receives contributions while the employee is working, invests the funds and thereby provides adequate reserves to pay lifetime benefits. Social Security collects taxes this year to pay benefits next year; there are virtually no reserves and periodically Social Security gets into financial trouble when Congress grants benefits that exceed Social Security's ability to pay. Congress then either raises taxes, or goes further in debt to future generations. Ohio STRS does not transfer benefit costs to the next generation.

4. Reserve funded systems like Ohio provide a pool of capital for financing American business and industry while at the same time safeguarding the funds needed to pay benefits.

5. Mandating of Social Security coverage for Ohio teachers is creative bookkeeping since such action will increase, not decrease, the Federal deficit in the long term when benefits become payable. One year's group of new teachers would create a long range deficit of $162 million for this system. Social Security benefit payments would exceed Social Security taxes over the working lives of this group of teachers by $162 million. This debt would be incurred for each new group of teachers entering the system, assuming a static group of 7400 new teachers yearly.

6. Future improvements in benefits for the existing program for Ohio STRS would, for all practical purposes, be forestalled since the administration of this fund would have to concern itself with Social Security benefit and rate changes that may be made in the future.

7. The determination of the various components of pension programs within Ohio and other states ought to be left to the states and not dictated by the Federal government.

To summarize, Ohio teachers have an actuarially funded program for retirement and other benefits which are superior to the Social Security programs. This program was developed and funded in 1920 and is recognized throughout the nation as a leader in program content and administration.

Forcing Ohio teachers to participate in Social Security and Medicare adds to the Federal debt rather than reducing it and Ohio teachers have no interest in participation in this Federal program.

We appreciate the opportunity to present this statement to the Finance Committee.

9/12/85
VAM:ed

HUSCH, EPPENBERGER, DONOHUE, ELSON & CORNFELD

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REPLY TO ST LOUIS

August 25, 1985

Ms. Betty Scott-Boom
Committee on Finance
Washington, D.C. 20510

Dear Ms. Scott-Boom:

On September 11 through September 13, 1985 the Senate Finance Committee is scheduled to hold hearings on methods to reduce the budget deficit. I am not scheduled to make an oral presentation, but would nevertheless like to forward to the Committee copies of the enclosed article, recently published in the St. Louis University Law Journal.

I have also enclosed a Commentary from the St. Louis Post-Dispatch summarizing the longer article for those members interested in a brief overview of proposal. Thank you for your consideration in this matter.

Sincerely,

John A. Newman

John A. Newman

ST. LOUIS POST-DISPATCH

commentary

The Case For A New Tax

A Small Levy On Checks And Other Financial Clearings Could Raise Billions

By John A. Newman

The national debt, expected to reach $2 trillion by 1986, is seriously jeopardizing this country's prospects for a successful transition into the next century. Central to the country's effort at deficit reduction will be the government's resourcefulness and commitment to cut spending and to restructure our federal tax policy, now considered to be in disarray.

Recent studies suggest, though, that even with all feasible cuts in defense and non-defense spending, annual deficits of at least $100 billion will remain. With Commerce Department estimates showing GNP growth has slowed, it would be improvident to expect economic growth alone to provide the additional $100 billion in revenues. The necessary revenues must be raised and they must be raised through increased tax collections.

Several proposals have been made to restructure our present tax system into a modified "flat rate" income tax whereby numerous tax preferences encumbering the present system would be eliminated in exchange for lower marginal tax rates. These proposals, while addressing the urgent need for fundamental tax reform, are not designed to raise any more revenue than the present system. Accordingly, if the additional $100 billion of revenue is to be raised, then it must come from a source other than the income tax.

Until recently, the most likely candidates for raising additional revenue were proposals for a European style value-added tax (VAT) and the closely related idea for a national sales tax. Both proposals, however, have been criticized and rejected for their narrow tax bases and high rates, which tend to escalate over time, for the additional administrative burden that they would place on business and government, and for their pre-emptive effect on existing state sales taxes.

One alternative that has not yet been considered is for a comprehensive, low-rate transfer tax imposed on checks and other payments as they move through the bank clearance process. Similar in operation to exchange fees imposed by institutions engaging in "nonpar" banking at the turn of the century, a modern-day "par" tax on checks, drafts and electronic payments would penetrate deeply into the fabric of the everyday economy, co-exist with the lowest possible profile and, most importantly, raise considerable amounts of revenue. Presently, more than 90 percent of all payments in this country — approximately $220 trillion — pass through existing payment mechanisms each year. At an effective rate of one-twentieth of 1 percent (.0005), a "par" tax could raise $110 billion, enough to balance the budget, restore this country's finances and facilitate transition to a "modified flat rate" income tax system.

There are a number of advantages to a "par" tax. First, of course, the tax is exceptionally simple and easy to pay. With minimal taxpayer involvement, this "nickle and dime" tax would be collected automatically as payments are cleared through the U.S. payments mechanism. Revenues would be remitted immediately to the closest Federal Reserve Bank, already empowered to act as fiscal agent of the Treasury Department.

The par tax does not require tax returns or other "self-assessment" and would thereby save the government and taxpayers millions in administrative costs. Unlike the value-added tax, the par tax can take advantage of a highly refined payment mechanism already in existence, thus avoiding the need for another layer of bureaucracy.

Moreover, the sheer breadth of the tax base and the low rate of the par tax avoids the pre-emptive effect on state sales taxes encountered under both the VAT and the national sales tax.

At a rate of one-twentieth of 1 percent, the tax burden on the purchase of $100 of groceries would be 5 cents; a weekly paycheck of $500 would yield 25 cents; an $800 mortgage or rent payment: 40 cents; purchasing a $10,000 automobile would cost an additional $5 and buying $100,000 worth of securities would cost $50.

At the institutional level, the par tax on a $500,000 equipment purchase would be $250; a $2 million wire transfer would cost $1,000 and a $40 million office building would cost an additional $20,000. At a rate of one-twentieth of 1 percent, the par tax would be the functional equivalent of less than two days' investment "float," with the largest portion of the tax payable by institutions in the best position to defray the cost through cash management efficiencies. Reliance on a par tax would diversify the tax base, reduce dependence on the income tax and provide a stable flow of revenue. Revenue stability, in turn, would provide greater certainty in funding of government programs.

And if the Treasury were given authority to adjust par tax rates across a predetermined range, there could be greater coordination between tax and monetary policy, stabilizing the economy as a whole. Vesting monitoring authority in the Treasury (or in the Federal Reserve, as fiscal agent of the Treasury) would help remove fiscal policy to a more politically isolated vantage point, thus reinforcing the integrity of the tax system.

John A. Newman is a tax attorney in St. Louis.

Pat N. Miller
Executive Secretary

COMMONWEALTH OF KENTUCKY
TEACHERS' RETIREMENT SYSTEM
216 WEST MAIN STREET
FRANKFORT, KENTUCKY
40601

September 4, 1985

Senator Robert Packwood, Chairman
Senate Finance Committee
U. S. Senate
Washington, D. C. 20510

Dear Senator Packwood:

I am writing to express the concern and alarm of the Kentucky Teachers' Retirement System about the prospect of the Congress mandating Social Security and Medicare contributions for Kentucky's public school teachers.

The Kentucky Legislature enacted legislation in 1938 establishing the Teachers' Retirement System. This legislation was necessary because the federal government did not permit public employees to participate in the Social Security System. Kentucky's teachers have had and continue to have a financially sound retirement plan and are certainly opposed to being required to make Social Security payments, particularly under the guise of reducing the federal deficit. Rather than reducing the deficit, the result over the long term would only greatly increase the financial obligations of the federal government. Mandatory coverage is nothing more than a new tax being imposed on state and local governments and the employees of those subdivisions who have provided fiscally sound retirement plans over the years.

Kentucky teachers contribute 9.6% of their salary toward retirement and the state provides 12.85% of each employee's salary. To add Social Security on top of these amounts would not be fiscally possible. The net result would be to reduce the benefits under a very sound plan in order to accommodate Social Security. Kentucky does not want to water down its benefits for teachers under the mistaken assumption that the deficit is being reduced. Even if the proposal contains only new hirees, it would only be a very few years before the costs would escalate drastically related to mandatory coverage.

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It would appear to be impossible for state and local governments to budget for this expense by January 1, 1986. Regardless of the implementation date of mandatory coverage the fiscal effects would be extremely serious.

Public retirement systems, including the Kentucky Teachers' Retirement System, have built their reputations on providing promised benefits at reasonable costs to the membership. The package of benefits provided by these systems as a general rule surpass the benefits provided under Social Security in almost all cases.

We are further concerned that funds now provided by public retirement systems for investment capital will be impaired. Enactment of mandatory Social Security coverage would certainly reduce the available funds for capital improvement. The Kentucky teachers' plan currently has assets of almost $2 billion and if members are required to pay for Social Security a reduction will have to be made in their retirement contributions. The funds so diverted to Social Security will not likely be used for capital investment in the private sector.

In summary, mandatory Social Security and Medicare contributions for teachers in Kentucky would have some very adverse effects:

1. It would not reduce the federal deficit.
2. It would increase the long term financial obligations of the federal government.
3. It would reduce benefits in an already sound retirement plan which are basically superior to Social Security.
4. It would place additional financial burdens on already burdened state and local governments.
5. It would reduce the funds needed for capital investment in the United States.

On behalf of the Board of Trustees of the Kentucky Teachers' Retirement System, I ask you and each member of the Senate Finance Committee to reject the idea of mandatory Social Security and Medicare coverage.

Sincerely,

Pat N. Miller

Pat N. Miller
Executive Secretary

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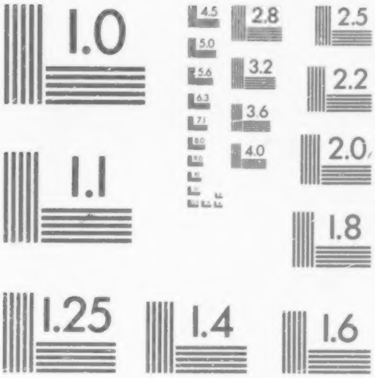
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